ISSUE BRIEF
The Massachusetts Health Policy Forum

Accelerating Adoption of the Collaborative Care Model (CoCM) in Massachusetts: Effectively Integrating Behavioral Health and Primary Care

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EXECUTIVE SUMMARY

This Issue Brief addresses the escalating crisis in availability of timely, affordable, and effective treatment for mental health and substance use disorders (MHSUDs) and proposes leveraging the primary care system through implementation of the Collaborative Care Model (CoCM). An extensive evidence base suggests that CoCM, by integrating MHSUD care into primary care, can alleviate years of needless suffering for those living with MHSUDs, reduce burnout among primary care providers (PCPs), reduce suicide risk, and lower total healthcare costs.

Seeking care for MHSUDs is far more challenging than it is for other medical conditions. The supply of licensed MHSUD specialists is insufficient to meet the growing demand for services, and their rate of participation in insurance networks is far lower than it is for other medical specialists. Patients often spend weeks or months trying to locate and schedule a timely appointment with an in-network (INN) MHSUD provider accepting new patients. [1] Those with acute needs who cannot afford the higher out-of-pocket costs associated with out-of-network (OON) care endure excessive wait times for appointments or forego care entirely.

Simply increasing the number of MHSUD specialists will not solve the problem. Evidence is clear about the clinical and cost benefits of CoCM. Leveraging our primary care system as an integral part of the solution, we can manage the delivery of MHSUD care the way we manage the delivery of other specialty medical care. For patients with cardiac conditions, for example, the primary care provider (PCP) systematically screens for and measures cardiac symptoms, provides care for non-acute patients, and refers more complex patients to a cardiologist for specialized care. There is no reason to treat patients with MHSUDs differently.

In this Brief we are proposing to increase access to needed MHSUD care across the Commonwealth through our existing primary care system - by providing PCPs with additional tools and support necessary to effectively address most of the MHSUD needs of their patients. While several models exist for integrating MHSUD care into primary care, we are recommending broadscale adoption of the Collaborative Care Model (CoCM) because of its abundant and compelling evidence base.

CoCM is a very specific approach to integrating MHSUD treatment into primary care. Under CoCM, a psychiatric consultant and behavioral care manager become part of the primary care team to help the PCP effectively identify and treat most non-acute MHSUDs. It is a low-cost intervention that has been shown to deliver significant benefits. With an evidence base that includes more than 90 randomized controlled trials and numerous "real world" studies in day-to-day primary care settings, CoCM has been shown to improve MHSUD patient outcomes, patient and provider satisfaction, and health equity, while reducing PCP burnout, suicide risk, and total healthcare costs. A growing consensus among Massachusetts payers, providers, and policy leaders is that CoCM offers the best scalable and self-sustaining solution to the challenges of patient access and integrated behavioral health and primary care delivery.

Importantly, CoCM does not increase the size of a PCP's patient panel; its focus is on patients already being seen by the PCP who otherwise are not being adequately screened/diagnosed/treated for MHSUDs.

PCP burnout is a major concern across the country and is a top priority in Massachusetts. PCP burnout can be attributed to a number of factors, including increasing administrative burdens and inadequate resources to treat complex patients – in particular, those patients with co-morbid mental health and chronic care needs[2]. CoCM offers an opportunity to reduce PCP burnout by providing a strong support system to help PCPs manage their patients' MHSUD needs more effectively than in traditional practice.

Broadscale adoption of CoCM provides an opportunity to increase access to timely, effective, and affordable MHSUD care for the greatest number of residents of the Commonwealth in the shortest period of time - while mitigating cost growth.

A number of actions have been taken within the Commonwealth in recent years to facilitate expansion of CoCM. However, there are key issues remaining to be addressed, including billing and reimbursement.

In order to maximize adoption and financial self-sustainability of the model for providers, it is important to ensure adequate reimbursement for all CoCM providers – including Federally Qualified Health Centers (FQHCs). For example, where Medicaid reimbursement for CoCM is less than 100% of Medicare rates, or FQHCs/RHCs are required to use a single, unique billing code for CoCM rather than the CoCM billing codes authorized by CMS and accepted by other payers, the cost to Medicaid for delivering CoCM will be lower, but the adoption of CoCM – along with its corresponding benefits, including reductions in total healthcare costs - will also be limited.

Beyond making CoCM more available to primary care patients, to optimize its impact we can maximize patient engagement in CoCM by waiving cost-sharing requirements.

And we can do more to assist providers in identifying financial and operational resources and support that can facilitate implementation and sustainability of CoCM in primary care practices across Massachusetts.

In order to capitalize on the progress made to date and further accelerate adoption of CoCM across Massachusetts, we are proposing the following policy recommendations.

Policy Recommendations to Accelerate Adoption of CoCM

1 Medicaid Coverage for CoCM:

a. Provide reimbursement rates for CoCM codes at least equivalent to Medicare rates.
b. Permit FQHCs/RHCs to use the CoCM CPT codes and G2214, in lieu of G0512.
c. Reimburse for CoCM separate from, and in addition to, any care management fees, primary care capitation, or other global payments.

2 Employer and other Commercial Plans:

a. Incentivize providers to adopt CoCM through implementation grants and adequate reimbursement – at least 130%–150% of Medicare FFS reimbursement rates.
b. Encourage patient participation by
    i. treating CoCM as a preventive service, thereby requiring waiver of out-of-pocket CoCM expenses wherever permitted. and
    ii. permitting providers to bill for CPT add-on code 99494 (continued CoCM care) as frequently as clinically indicated.
c. Reimburse for CoCM separate from, and in addition to, any care management fees, primary care capitation, or other global payments.

3 Legislators and Regulators:

a. Allowing in-network CoCM services to count as in-network MHSUD specialist services when assessing Mental Health Parity compliance and network adequacy.
b. Legislation
    i. Enact legislation currently proposed in Massachusetts requiring that reimbursement for CoCM is separate from, and in addition to, any care management fees, primary care capitation, or other global payments.
    ii. Note these Bills filed in the Massachusetts House and Sente in 2024: H.2220 (Rep. LaNatra), *An Act relative to access to psychiatric collaborative care;* S.1390 (Sen. Cyr), *An Act relative to access to psychiatric collaborative care.*
    iii. Permit FQHCs/RHCs to bill using CoCM codes, in lieu of G0512.
    iv. Designate CoCM as a preventive service, thereby requiring waiver of patient out-of-pocket CoCM expenses wherever permitted.
    v. Permit providers to bill for CPT add-on code 99494 (continued CoCM care) as frequently as clinically indicated.

4 Philanthropic and System Funders:

a. Build on successful CoCM adoption initiatives underway or completed.
b. Develop a fund to underwrite costs for practice transformation, technical adjustments to medical records, patient registries, and billing systems, and recruitment and retention of embedded behavioral health clinicians and care managers.

5 Providers: Expand implementation of CoCM, taking advantage of a growing pool of resources to assist with implementation – such as those described in this Directory of CoCM Service Organizations for consultation, training, billing support, patient registries, and ongoing staffing.

INTRODUCTION

One in five Massachusetts residents experiences a mental health condition in any given year, yet only half of that number receive treatment.[3] Of those who do, many experience fragmented care, with mental health screening and specialty treatment siloed from primary care. Nationwide, we are facing an unprecedented and steadily growing crisis in accessibility to treatment for mental health and substance use disorders (MHSUDs). Despite enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) more than 15 years ago requiring insurers to provide the same level of coverage for MHSUD care as provided for medical/surgical care, evidence consistently shows that accessing timely, affordable care for MHSUDs is far more challenging than accessing such care for physical health conditions,[4 5 6 7 8] and evidence shows that these disparities in access are widening. [9]

The most recent U.S. data show that the percentage of adults who needed but did not receive behavioral care due to cost rose from 4.2% in July-September 2021 to 5.5% in October-December 2023.[10] Similarly, a survey of nearly 3,000 people regarding access to medical and MHSUD care revealed that more than half (57%) of those who sought MHSUD care were unable to access any care on at least one occasion between January 2019 and April 2022.[11]

Inadequate access to MHSUD care is costly to everyone: missed or delayed MHSUD diagnoses, needless patient suffering, rising suicide rates, and billions of dollars spent in avoidable medical costs. The impact extends beyond the individuals living with MHSUDs: insurers, employers, and health insurance premiums are all affected. Individuals with co-occurring MHSUDs and physical health conditions incur substantially higher total healthcare costs – most of which relate to physical healthcare services. [12]

Table 1. Average Annual Healthcare Treatment Costs per Individual by Behavioral Health Category, 2017 Total Population (Milliman Study) [13]

FIGURE 9 EXCERPTS FROM MILLIMAN: AVERAGE ANNUAL HEALTHCARE TREATMENT COSTS (SERVICES AND PRESCRIPTION DRUGS) PER INDIVIDUAL BY BEHAVIORAL HEALTH CATEGORY, 2017 TOTAL POPULATION

BH CATEGORY	INDIVIDUALS		AVERAGE ANNUAL HEALTHCARE COSTS		% OF COSTS FOR BEHAVIORAL HEALTH	COSTS RELATIVE TO "NO BH"
	NUMBER	%	BEHAVIORAL HEALTH	MEDICAL/ SURGICAL		MEDICAL/ SURGICAL
No BH	15,275,323	73%	$0	$3,552	0.0%	1.0x
Any MH	5,317,964	25%	$1,017	$11,204	8.3%	3.2x
Any SUD	908,499	4%	$1,989	$17,807	10.0%	5.0x
Both MH and SUD	492,465	2%	$3,413	$22,189	13.3%	6.2x
Total Population	**21,009,321**	**100%**	**$263**	**$5,669**	**4.4%**	**1.6x**

BH = Behavioral Health condition
MH = Mental Health condition
SUD = Substance Use Disorder

There is a well-documented shortage of licensed MHSUD specialists available to meet the need for care. Massachusetts policymakers and providers have taken numerous steps to address this problem, including establishing several funds to support scholarships, cover loan forgiveness, underwrite training programs, and further examine solutions. Massachusetts is of course endeavoring to increase the number of these providers, and there is evidence that these shortages are decreasing. However, this alone will not resolve

the access crisis in the short run and will not be an adequate solution in the long run. Most residents of Massachusetts – as most Americans generally - rely on public or private health insurance and the availability of in network (INN) practitioners to minimize out-of-pocket costs and make healthcare affordable. When the availability of INN practitioners is insufficient to meet the needs of beneficiaries, patients endure excessive wait times for appointments, seek more timely care from out-of-network (OON) practitioners, or forego care entirely.

MHSUD providers participate in insurance networks at a far lower rate than other medical specialty providers. [14] [15] As a result, people with MHSUDs often spend weeks or months searching for an INN MHSUD provider currently accepting new patients, and many will end up receiving no care at all.[16] Not surprisingly, studies show disproportionately higher use of out-of-network (OON) providers by patients seeking care for MHSUDs versus patients seeking care for other medical conditions.[17] The higher out-of-pocket costs associated with OON care create an inequitable system that favors those who can afford this higher cost. For those who cannot, the choice often comes down to delayed treatment with an INN provider or no treatment at all.

Telemedicine has proven effective in treating patients receiving collaborative care for more than a decade.[18] Increasing use of telemedicine, spurred by the Covid-19 pandemic, has enabled more patients to receive timelier MHSUD care, and recent studies underscore its utility, including with older adult populations.[19] However, this model still requires the same limited MHSUD workforce to deliver the care. Similarly, the use of digital applications has broadened access for a number of people. Both of these modalities are relatively new and coverage for these services, while expanding, is still somewhat limited.

To close the gap between the growing need for MHSUD services and our capacity to meet this need, we will benefit from solutions that can leverage the resources we currently have, giving us the opportunity to increase access to effective MHSUD care for the greatest number of people in the shortest period of time.

The Role of Primary Care

There is now abundant evidence that tells us that the greatest near-term opportunity for achieving this lies in leveraging our primary care system. We need to view the role of primary care in MHSUD treatment the same way we view it in other medical specialty treatment. For example, in cardiac care the primary care provider (PCP) serves as a "front line" to systematically screen for and measure cardiac symptoms, provide care for non-acute patients and refer acute or unusually complex patients to a cardiologist for more comprehensive specialized care. The same should be happening in MHSUD care.

As the importance of addressing patient needs from a "whole health" perspective continues to shape our healthcare system, the primary care sector is ideally suited to play a central role in increasing access to effective, timely and affordable INN care for MHSUDs:

- Most office-based MHSUD care is provided, and most psychiatric drugs are prescribed, by primary care providers (PCPs)[20] [21]
- Primary care is the only source of MHSUD care available for many Americans[22]
- Patients prefer to receive MHSUD care services in the primary care setting [23]
- A large majority of patients who die by suicide have visited a primary care provider in the prior year, with almost half having done so in the prior month [24] [25] [26] [27] [28] Persons with co-occurring MHSUDs

and physical health conditions incur 3 - 6 times higher total healthcare costs - driven heavily by physical healthcare expenses. [29]

PCPs want to be able to address their patients' MHSUD needs, but they do not typically have adequate expertise or support to effectively identify and treat these conditions – leading to delayed diagnoses and ineffective clinical care. It is estimated that only 13% of people diagnosed with a mental health disorder receive minimally adequate treatment in the general medical setting, and this percentage is just 5% for those with substance use disorders. [30]

A patient experience survey conducted by NORC[31] between December 2021 and April 2022 with funding from the Bowman Family Foundation found that 87% of patients of all ages who received mental health or substance use care from physical health providers felt that they needed additional help from a mental health or substance use specialist. For adolescents, based on responses provided by parents/caregivers/providers, 98% of patients who received mental health or substance use care from physical health providers needed additional help from a mental health or substance use specialist.

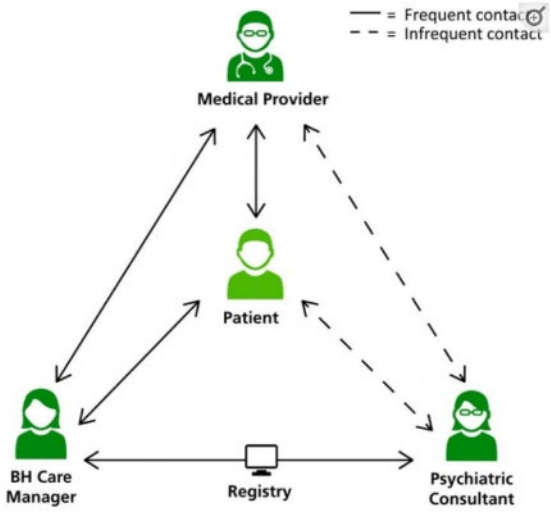
Similarly, while early screening for most medical conditions in primary care settings is considered routine care, this is not the case for MHSUDs.[32] The average time between symptom onset of a MHSUD and treatment is 11 years[33]- due in part to the fragmented system of care where even screening and frontline treatments rely on specialty rather than primary care.

These observations are not new. Various policy, regulatory, financing, and service demonstration work focused on integrating behavioral health and primary care to address the whole health of individuals, particularly on adults with multiple chronic health conditions, has been in progress for more than 40 years at state and federal levels. [34] Efforts to integrate care in safety net health systems, where more people with disabling and chronic health and behavioral health conditions were served and were driving high costs, tended to focus on primary care behavioral health integration models that relied on behavioral health clinicians consulting to or embedded in primary care practices.[35] In parallel efforts with large groups of commercially insured individuals, what is now known as the collaborative care model was implemented in numerous sites, with different patient populations under study.[36] Integration models implemented and evaluated included co-location, disease management, primary care behavioral health integration, and collaborative care[37] Appendix A outlines a comparison of four common integration models by patient population, service elements, care management methods, and revenue generation.

The Collaborative Care Model

The Collaborative Care Model (CoCM) is a low-cost, evidence-based approach to integrating treatment for many commonly occurring MHSUDs, such as depression and anxiety, into primary care settings. It helps PCPs confidently address their patients' MHSUD needs just as they do for other specialty conditions. The model enables PCPs to effectively identify and treat these conditions through a multidisciplinary team that includes one or more behavioral health care managers and psychiatric consultants. CoCM can close the gap between the onset of MHSUD symptoms and the initiation of treatment by identifying conditions at the primary care visit – especially important for children and adolescents - and implementing an effective treatment plan overseen by the PCP and monitored by the team. CoCM leverages the existing primary care system to increase access while simultaneously enhancing the capacity of the existing MHSUD delivery system: a psychiatric consultant can help many more MHSUD patients under CoCM than through traditional MHSUD care.[38] [39]

About CoCM:

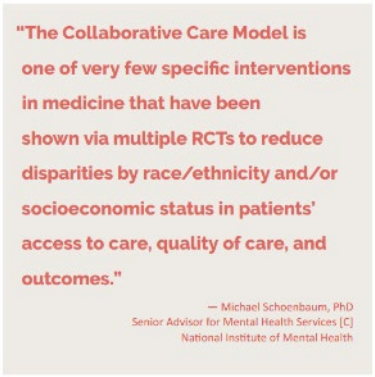


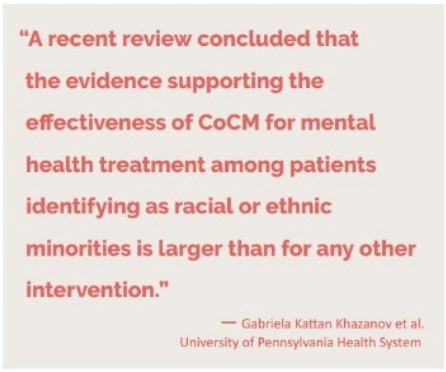
Under CoCM, the primary care clinician manages behavioral health for patients as a population. Patients are screened for behavioral health conditions. Those who meet clinical criteria are invited to enroll in CoCM. Primary care clinicians work with behavioral care managers, virtually or onsite, to offer evidence-based treatments. Treatment plans include measurable clinical goals and patient goals. Patient outcomes are measured and tracked in a registry. Treatment plans are regularly adjusted for patients who are not improving as expected, with support from a psychiatric consultant.

AIMS Center, University of Washington

Since 2002, an extensive evidence base has accrued on the benefits of CoCM. In more than 90 randomized controlled trials, supplemented by multiple meta-analyses and "real world" studies in day-to-day primary care settings, CoCM has been shown to improve MHSUD patient outcomes, patient and provider satisfaction and health equity.[40] [41] [42]

The American Psychiatric Association has recommended specific strategies in delivering CoCM to reduce racial and ethnic inequities in mental health, including targeted screening and outreach, cultural tailoring of services, an integrated, diverse workforce and quality assessment using Measurement Based Care.





Studies have also documented CoCM's positive impact on suicide risk and total healthcare spending. Implementation of CoCM – or key elements of the model - has been linked to reductions in suicide risk in more than 50% of "at risk" patients, as well as a 25% reduction in suicide attempts and deaths in a study population of more than 225,000 primary care patients. [43]

Table 2. Key Studies Demonstrating Reduction in Suicide Risk Under CoCM

Study Sponsor	Number of Patients Screened / "At Risk"	Key Outcome Measure	Reduction of Risk and Deaths
Concert Health 52 providers (health systems or practices) 16 states	**29,507** screened and included in CoCM analyses **3,809** identified as "at risk"	Suicidal ideation	**% of "at risk" patients with *reduced risk*** Avg. all doses[a] **56%** High dose[b] **76%** Percent of "at risk" patients who achieved remission[c] **49%**
University of Pennsylvania Health System 19 practices 2 states	**3,487** screened and included in CoCM analyses **368** identified as "at risk"	Suicidal ideation	**% of "at risk" patients with *reduced risk*** Avg. all doses[d] **52%** Percent of "at risk" patients who achieved remission[c] **37%**
Kaiser Permanente[e] 19 practices 1 state	**228,255** screened and included in integrated care analyses[f]	Suicide attempts and deaths (combined)	**Reduction of attempts and deaths** **25%**[g]

a Dose = Length of Collaborative Care Model (CoCM) treatment, between 8 days and 6+ months.

b 6+ months of treatment.

c Remission is defined here as the absence of detectable suicide risk, based on the assessment tool used (C-SSRS in the case of Concert Health; PHQ-9 in the case of the University of Pennsylvania). Note: Patients who had detectable risk at one point, but currently have no detectable risk, are still considered to have a higher risk of suicide than patients who have never had a detectable risk.

d Dose = Length of CoCM treatment, between 15 days and 6+ months.

e Conducted in primary care. Included systematic screening of patients for depression/suicide risk, integration of a behavioral health clinician, and referral of "at risk" patients to the behavioral health clinician for prompt safety planning.

f The number of "at risk" patients is not available.

g In comparison to a control group of 255,789 patients.

Source: Large Reductions in Suicide Risk, Attempts and Deaths Demonstrated by Three "Real World" Studies in Primary Care

Further, numerous studies have demonstrated savings in total healthcare costs [44] [45] [46] [47] [48]- savings that are driven by reductions in physical healthcare expenditures. These savings have been shown to persist, and even grow, over time.[49] This is important because CoCM has been highly effective in treating patients with co-occurring MHSUDs and physical health conditions such as cancer, diabetes, and HIV.

Table 3. Studies Showing Reduced Healthcare Costs Under CoCM

Study	Key Findings/Conclusions
Simon et al., 2007 [45]	Over a period of 24 months, CoCM patients had approximately $300 lower outpatient (OP) healthcare costs and 61 more depression-free days, compared to patients in usual care.
Katon et al., 20124[46]	CoCM patients had 114 more depression-free days, and lower mean OP health costs of $594 per patient than usual care patients.
Unützer et al., 2008 IMPACT Study, University of Washington4[47]	Over 4 years, CoCM group THCs were $3,363 lower than patients receiving treatment as usual. Cost savings occurred in every care category and increased over years 2-4.
Wolk et al., 2023 Penn/IBX Study[44]	During the 12 months following initiation of CoCM, THCs were essentially the same (i.e., a non-statistically significant savings of $29.35) for CoCM patients versus matched patients receiving treatment as usual, despite the fact that CoCM patients received more mental health care (i.e., savings accrued in physical health care).
Kaiser Permanente, 2023[48] (previously unpublished)	During the 12 months following initiation of CoCM in this 2015 study, there was a 13% per member per month (PMPM) THC savings for CoCM patients as compared to the "treatment-as-usual" comparison group.

Given the current focus on primary care access in Massachusetts, it is important to note that CoCM does not generate an increase in new PCP patients. CoCM helps PCPs more effectively manage their existing patients who may be receiving inadequate or no treatment for MHSUDs. Practices are generally overburdened, under-reimbursed, and understaffed. Yet, patients seen in primary care practices may have emerging medical conditions and undiagnosed MHSUDs in addition to living with multiple chronic health conditions. Among those who are treated, MHSUD symptoms are often not systematically measured/monitored for clinical response and appropriate treatment adjustments. Per provisions of Chapter 177 of the Acts of 2022, Massachusetts residents are now entitled to an annual Mental Health Wellness Exam. [50] CoCM provides PCPs with the expertise and support needed to address their patients' MHSUD needs and maximize effective response to positive screens.

Any form of care integration requires some level of effort and resources to implement and sustain, and adequate reimbursement levels for CoCM allow primary care practitioners to be compensated for these resources. In states where all payers reimburse for CoCM - at adequate rates - the cost of delivering CoCM can be recovered through claims reimbursement for the CoCM billing codes. At the same time, savings in total healthcare costs can accrue to all payers (Medicaid, Medicare, commercial insurers, and employers) as detailed in the studies outlined in the preceding section.

Policy Considerations for CoCM Implementation in Massachusetts

Broadscale adoption of CoCM in Massachusetts will require that actions be taken by multiple stakeholders, including Medicaid, Commercial insurers, Legislators and Regulators, philanthropic partners and providers, to minimize barriers and increase incentives to CoCM adoption.

Successful implementation will be facilitated by making the transition as easy as possible for all stakeholders while operating within the Commonwealth's current policy environment. Increasing

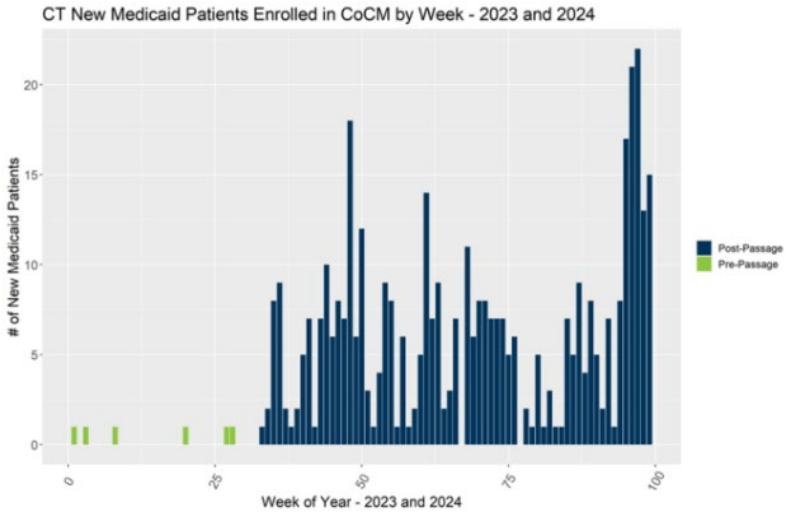
equitable access to affordable MHSUD care through CoCM includes incentivizing provider adoption and patient engagement in CoCM. Below are some considerations that can impact broadscale adoption of CoCM in Massachusetts. In our Policy Recommendations below we highlight how each key stakeholder group can contribute to successful CoCM adoption.

Incentivizing Provider Adoption: Medicaid Coverage and Reimbursement

To achieve broadscale adoption of CoCM, it is important that all payers cover the services – at adequate reimbursement rates – so providers can realize the economies of scale in implementing CoCM for all patients. Today, Medicare, most commercial payers, and Medicaid programs in more than thirty states – including Massachusetts - reimburse primary care providers for delivering CoCM, using payment codes developed by CMS. Coverage of the CoCM codes by Medicaid has become a particularly critical factor for CoCM adoption. In states providing adequate Medicaid reimbursement for CoCM, the number of patients treated under CoCM increases across **all** payers.[51] [52]

The figure below shows the impact of Medicaid coverage of CoCM in Connecticut on patients covered under Medicaid, Medicare and commercial insurance referred into CoCM before and after Medicaid coverage became effective in September 2023.

Table 4. Connecticut's New Medicaid Patients Enrolled in CoCM by Week – 2023 and 2024



Source: Concert Health

Appendix B summarizes Medicare behavioral health codes applicable to CoCM, their adoption in Massachusetts, and Massachusetts reimbursement rates for Medicare compared to MassHealth. Unless otherwise noted, Medicare rates were identified from the Medicare Physician Fee Schedule Lookup Tool online.[53] This summary suggests several ways in which CoCM adoption is disincentivized relative to less effective co-location or referral systems.

Massachusetts adoption of CoCM billing codes has lagged Medicare. In addition, whereas MassHealth matches Medicare rates for psychotherapy and psychiatric consultation, it pays less than Medicare for

CoCM codes. This means CoCM is disincentivized for Medicaid members relative to Medicare beneficiaries. Moreover, given the workforce crisis for licensed behavioral health clinicians in the Commonwealth, the staffing model for CoCM, using a BA level care manager, rather than an MA level licensed clinician, makes more sense for the long established positive clinical and cost outcomes, the relative ease of recruiting and retaining BA level staff, and the efficiency of using another class of professionals that does not place additional demand on the limited licensed clinician workforce.

The lag has been especially long in settings where CoCM may be most needed, FQHCs and RHCs. Even when implemented, reimbursement rates for CoCM in FQHCs and RHCs have been lower than for primary care practices. Primary care practices can bill the CMS-authorized CoCM codes (99492, 99493, 99494, G2214) as long as they can document that the time spent was at least half of the allocated time - plus one minute - for each respective CoCM code. FQHCs and RHCs must document having spent all of the allocated time for the single billing code they are required to use (G0512).

When Medicaid reimburses at less than 100% of Medicare rates, or when FQHCs/RHCs are required to use billing code G0512, the aggregate cost of delivering CoCM is lower – but adoption of CoCM is constrained and its corresponding benefits, including reductions in total healthcare costs, are also limited.

To address the issues of both access and affordability, MassHealth has been providing periodic increases in reimbursement rates for behavioral health services and has expanded the types of professionals who can bill and settings from which services can be delivered and billed.[54] [55] [56] [57] However, MassHealth rates paid for CoCM codes fall well below Medicare rates, presenting a significant impediment for broader adoption of CoCM. In the current session of the Massachusetts General Court, the Legislature is considering House and Senate bills to increase these rates to 100% of Medicare rates.[58]

CoCM can also be financed through value-based care arrangements, but the MassHealth ACO structure disincentivizes implementation. Fee-for-service arrangements pay providers per service delivered, incentivizing providers to deliver more care. By contrast, value-based payment arrangements incentivize providers to keep populations healthy at a lower cost. Such arrangements are increasingly common across the nation and in Massachusetts.

Under some value-based care arrangements, payers provide incentives and flexibilities that enable primary care transformations. These arrangements can include:

- Upfront investments to fund practice transformation
- Per member, per month (PMPM) fees, instead of or in addition to fee-for service, and
- Higher payment for practices that provide more integrated care, or for practices that serve patient populations with higher health-related needs.

CoCM is a population health system, accountable to payers, and amenable to continuous quality improvement.[59] This makes it a natural fit to help health care organizations thrive under value-based payment arrangements.

One challenge in the implementation of CoCM for value-based models, however, is that incentives for good financial performance and health outcomes are calculated and paid annually, but CoCM may cost more than it returns in the initial 12 to 18 months. Newer value-based care models that provide upfront investments may help to mitigate this challenge. These include and are not limited to the ACO Primary Care Flex Model, which provides a one-time advanced shared savings payment of $250,000 to all

participating ACOs,[60] and the Transforming Maternal Health Model, which requires screenings for depression and anxiety among pregnant and postpartum women.[61]

As of this writing, value-based care arrangements in operation in Massachusetts include the MassHealth Accountable Care Organization (ACO) program; [62] Medicare Advantage Value-Based Insurance Design Model,[63] Care First Model Options,[64] REACH,[65] and BPCI Advanced.[66]

In addition, MassHealth's behavioral health carve-out[67] may be inadvertently disincentivizing population health approaches to behavioral health like CoCM. Behavioral health services are managed separately from physical health services and do not count towards primary care spending targets. For primary care clinicians who are trying to achieve cost savings in their first year, this program structure may disincentivize CoCM implementation (which would be counted against their expenditures) and may incentivize them to refer patients out for behavioral health services instead.

Availability of Affordable In-network MHSUD Care

Affordability is a long-standing issue in behavioral healthcare, partly due to low insurance participation by behavioral health clinicians. A 2024 JAMA commentary retraced to the 1950s the observation that more than half of psychiatrists' income comes from cash payments. The authors also pointed out that in 2010, 45% of U.S. psychiatrists did not accept any insurance, because of low reimbursement rates and high administrative burdens. The commentary further noted that psychiatrists were more than twice as likely to accept self-pay patients than they were to accept Medicaid patients.[68] Another recent study noted that Medicare participation among psychiatrists had declined from 60% to 55% between 2013 and 2019.[69] According to the Massachusetts professional societies, more than half of the mental health practitioners in Massachusetts do not accept insurance.

Even for those with health insurance, affordability can be an issue, because it is challenging to find an in-network clinician who is taking new patients. Those who can afford higher copays for out-of-network clinicians, and those who can fully pay out of pocket, get prompter service. A patient experience survey conducted by NORC between December 2021 and April 2022 with funding from the Bowman Family Foundation showed that 57% of U.S. patients surveyed who sought mental health or substance use care did not receive any care in at least one case, compared to 32% of those who sought physical health care. The survey also found that of the patients with commercial insurance who did receive outpatient mental health or substance use care, 40% had to contact 4 or more in-network providers before they were able to get an appointment, compared to 14% for physical care appointments, and 39% of patients in employer-sponsored health plans used an OON mental health or substance use provider at least once in the past 12 months. [70] For MHSUD providers such as psychiatrists and psychologists, Massachusetts has a high rate of OON care use, as detailed in a 2024 study on behavioral health parity across the states.[71]

A study conducted in 2013 showed that Massachusetts had higher psychiatrist insurance participation than the US overall, with 79% of psychiatrists participating in at least one insurance network. However, only 6% billed a full caseload (>=300 patients) to insurers. Furthermore, insurance participation was lowest for Medicaid managed care plans, and highest for commercial insurance plans.[72]

Patient Cost-sharing Discourages Patient Engagement

While CoCM improves access to MHSUD care and patient outcomes, patient copay requirements disincentivize patient engagement in CoCM, as confirmed by key informants interviewed for the MAMH Improving Outcomes Study.[73]

Patient cost sharing requirements are commonly utilized to discourage over-utilization of discretionary services. However, CoCM is a service that we would like to encourage patients to use - it is an effective, low cost MHSUD intervention:

- CoCM patient episodes are billed once a month
- Episodes can last 1 month or more than a year, but
  - Over 80% of episodes are ≤ 6 months* and
  - 4.1 months is the length of an average patient episode**
    - For all patients, including those in care more than a year
- Examples: Aggregate cost of 4-month episode**
  - Medicare, and Medicaid plans reimbursing at 100% of Medicare: $475 - $650
  - Commercial plans reimbursing at 150% of Medicare: $725 - $975

* Based on a large proprietary database of Medicaid, Medicare and commercial patients
** Based on various combinations of billing codes 99492, 99493, 99494 and G2214

Payers would be well-justified in offering first-dollar coverage of CoCM services, as several interviewed for the MAMH Improving Access Study indicated is their current practice.[74] **Waiving patient copays can improve the affordability and the utilization of CoCM - which improves total cost savings for payers**.

Impact on Primary Care Providers

PCP burnout is a major concern across the country and is a top priority in Massachusetts. It is possible that some PCPs in the Commonwealth may consider implementation of CoCM infeasible because of their current workload and resources. However, among the factors contributing to PCP burnout is having inadequate resources to treat complex patients–in particular, those patients with co-morbid mental health and chronic care needs.[75] PCPs are increasingly providing more complex care to patients without adequate resources to address their MHSUDs- putting further strain on an already-taxed primary care system.[76]

While many primary care providers in Massachusetts report being overwhelmed by increased demand for their services, burdensome paperwork, insufficient reimbursement, and short-staffed teams,[77] they are likely to experience an uptick in behavioral health diagnoses because of recently enacted policies in the Commonwealth to address MHSUD needs.

- The Massachusetts Mental Health ABC Act 2.0, signed into law on August 10, 2022 as Chapter 177 of the Acts of 2022, guarantees an annual mental health wellness exam at no cost to all patients across all payers. [78]
- The MassHealth Accountable Care Organization (ACO) Primary care Sub-Capitation Program (MassHealth ACO program), launched in 2023 as part of a Section 1115 Medicaid demonstration requires that practices participating in MassHealth ACOs conduct an annual and universal practice-based behavioral health screening of all attributed patients over the age of 21.[79]
- As part of its Roadmap for Behavioral Health Reform, implemented in 2023, [80] Massachusetts:
  - Launched a Behavioral Health Help Line (BHHL), providing assistance in over 200 languages to connect individuals and families to behavioral health treatment services;

- Created 25 new Community Behavioral Health Centers (CBHCs) with 24/7 mobile crisis services regardless of ability to pay; and
- Created Behavioral Health Urgent Care Centers at more than 70 CBHCs and Behavioral Health Clinics across the Commonwealth.

It is important to note that adoption of CoCM will not increase MHSUD patient caseloads a primary care practice. CoCM helps primary care clinicians meet the needs of existing patients with long-standing or newly-detected behavioral health needs.

While there are PCP responsibilities[81] in implementing CoCM, these are modest in comparison to the benefits CoCM can offer, and there are ample resources available to minimize the impact. CoCM provides a strong support system to help PCPs manage their patients' MHSUD needs, extending their capacity to address the needs of these patients well beyond what could be done in traditional practice. In addition, in recent years we've seen an increasing number of organizations created specifically to assist PCPs and health systems in implementing CoCM. A list of such organizations can be found HERE.

EXAMPLES OF SUCCESSFUL COCM ADOPTION

Three examples of CoCM adoption available from policy and case studies are described below, illustrating the feasibility and benefits of CoCM implementation for patients, providers and payers. Additional details regarding these examples can be found in the Appendices referenced below.

University of Pennsylvania Health System – PIC Program

Since 2018, the University of Pennsylvania Health System (Penn) has implemented CoCM in more than 50 primary care practices through a program called the Penn Integrated Care (PIC) program. PIC includes all core elements of CoCM, and adds features not traditionally included under CoCM. For example, while CoCM typically is offered to patients with mild to moderate MHSUDs, PIC provides these services for all patients to ensure that patients needing specialized care are supported. In addition, PIC incorporates a centralized intake, triage, and referral management function - the PIC Resource Center. This resource is designed to allow mental health professionals in practices to use their time more effectively to treat patients.

The PIC program is widely recognized as an example of successful CoCM implementation and growth. It has also been instrumental in adding to our understanding of the benefits of CoCM in primary care, demonstrating that CoCM can simultaneously improve patients' clinical outcomes and expand the capacity of one FTE psychiatrist by a factor of 10 (shown in Appendix C).

Two key studies utilizing data from the PIC program have been recently published pointing to the important role CoCM treatment can play in reducing total healthcare costs and suicide risk among primary care patients:

Impact of CoCM on Total Healthcare Costs

Impact of CoCM on Suicide Risk in Primary Care Patients

Additional details regarding the PIC program and the studies noted above can be found in Appendix C.

North Carolina – Expansion of CoCM in State Medicaid Program

North Carolina Medicaid created a Collaborative Care Model Consortium in January, 2022. The Consortium included primary care and psychiatric providers, payers, and other key community stakeholders. Their goal was to expand integration of mental health care in primary care for Medicaid beneficiaries using CoCM.

The Consortium identified two primary goals:

- Align coverage, requirements and payment across payers to validate that CoCM is an endorsed model worth adopting and reduce administrative burden for providers; and
- Encourage uptake by providing primary care practices with practice resources to make adopting CoCM as easy as possible and ensure that CoCM is implemented with fidelity.

Embedded within these goals were the following key strategies:

- Ensure Coverage of the Same CoCM Codes across payers
- Align Billing Requirements
- Make Reimbursement Sustainable
- Remove Beneficiary Copays
- Provide and Fund 1:1 Training for Providers
- Establish Connections with Psychiatric Consultants
- Customize and Fund a Statewide Registry

Details of these strategies, as well as key actions taken for each, can be found in Appendix D, which contains a copy of the Consortium's published CoCM report.

Over 18 months, Medicaid CoCM encounters grew significantly across the state. The Consortium now focuses heavily on helping practices effectively implement the model in a sustainable manner.

Kaiser Permanente – National Implementation of CoCM

In 2011 Kaiser Permanente Colorado implemented a pilot program for Depression Care Management that included key components of CoCM. The program was well received by patients and primary care providers and resulted in improved clinical outcomes for patients as well as a 13% savings in total healthcare costs (see Appendix C and the link below) for patients enrolled in the program.

Following the initial successes of the program, it was expanded in 2015 to all Kaiser Permanente locations, and in 2021 Kaiser Permanente made the decision to expand the program further to incorporate all elements of CoCM. A presentation detailing Kaiser Permanente's transition to CoCM enterprise wide is included as Appendix E

As with Penn, Kaiser Permanente has contributed to documenting the importance of CoCM in reducing suicide risk and total healthcare costs among primary care patients:

> CoCM and Total Health Costs (Previously unpublished information reported here)
>
> CoCM and Suicide Reduction

Efforts to Support Broadscale CoCM Implementation in Massachusetts and Examples of CoCM Adoption

Examining Research, Policy, Regulatory, and Reimbursement Structures

In Massachusetts, primary care clinicians are stretched thin[82] – but with the right supports, many unmet behavioral health needs could be addressed in primary care. While several models exist for behavioral integration (BHI) into primary care, the Collaborative Care Model (CoCM) - developed 25 years ago by the AIMS Center at the University of Washington. [83,84] - is supported by a large and especially compelling body of evidence, as detailed in an earlier section of this Policy Brief.

With philanthropic support as earlier acknowledged, the Massachusetts Association for Mental Health (MAMH) is working to illuminate effective solutions to the challenge of timely access to care and identified the Collaborative Care Model (CoCM) as a tested solution that is feasible to implement in the Massachusetts policy, regulatory, and reimbursement environment.

Policy, regulatory, and reimbursement structures that support integration of behavioral health in primary care and the adoption of CoCM were established in the Commonwealth in recent years. The introduction of larger payment and service delivery reforms and the urgency of COVID pandemic demands, however, undercut broad adoption of CoCM. In the pandemic recovery, Massachusetts found behavioral health and primary care workforce shortages in the face of increased demand for care.

As healthcare system leaders and policy advocates probed for solutions in recent years, the Massachusetts Association for Mental Health (MAMH) and the Network for Excellence in Health Innovation (NEHI) interviewed and convened policy, practice, and payer leaders. NEHI's 2023 Integrated Care Study, supported by CVS/Aetna Health, BCBSNC, Sunflower Foundation, Concerto Health, and NeuroFlow, analyzed models of care integration at a macro level, studying options for scaling behavioral health in primary care, *Scaling Behavioral Health Integration in Primary Care: Wading through the Complexity to Tackle a Decades-Old Challenge*. [85]In 2024, MAMH examined, with support from the Bowman Family Foundation and The Goodness Web, the research, policy, and practice landscape, including regulatory and reimbursement structures, for integration of behavioral health and primary care and feasibility of implementation of the Collaborative Care Model in the Commonwealth. MAMH interviewed health care system stakeholders – policymakers, patients, payers, and providers – incorporating their perspectives into the published report *Improving Outcomes for Patients with Behavioral Health Conditions in Massachusetts: Accelerating Implementation of the Collaborative Care Model*, which examines the evidence for adoption, explores the facilitators and challenges to implementation, and outlines steps to strengthen feasibility in adoption of CoCM.[86] Later in 2024, NEHI convened a number of those stakeholders and others with national experience, supported by several health plans, private Behavioral Healthcare companies, and Bowman Family Foundation to discuss the state of behavioral health and primary care integration, producing a report summarizing the initiative. [87]

With philanthropic support, policy research and convening of policymakers, payers, and providers in the Commonwealth revealed interest in care integration, a need for better understanding of CoCM, policy and regulatory actions needed to strengthen the implementation environment, and technical and financial resources needed to underwrite the costs of practice transformation.

Policy and advocacy initiatives are underway to advance CoCM adoption at primary care practices across the Commonwealth. Efforts are rooted in the growing consensus among Massachusetts payers, providers, and policy leaders that CoCM represents a real solution to the challenges of patient access and integrated behavioral health and primary care delivery. PCPs have identified a need for more system-wide awareness and education about CoCM, its proven benefits, and the path toward implementation, which requires practice transformation. The number of practices successfully implementing CoCM is growing in Massachusetts.

Examples of CoCM Adoption in Massachusetts

In 2016, the MassHealth Accountable Care Organization (ACO) pilot programs promoted a degree of behavioral health and primary care integration under a value-based payment model; with much of the value was retained at the ACO level. Later MassHealth reforms launched in 2023 more explicitly ensured payments for integrated primary care were made through sub-capitations to the practice level. The sub-capitations were paid in higher amounts for successive levels of care integration.

In 2018, following establishment of Collaborative Care and Integrated Care codes at CMS, the Commonwealth, under the MassHealth Section 1115 Demonstration Waiver, activated the codes enabling Medicaid (MassHealth) to cover CoCM. On March 15, 2022, SB2584 and HB4891 were authorized supporting reimbursement of CoCM through Medicaid and private insurers. On August 2, 2022, Massachusetts enacted Chapter 177 of the Acts of 2022, requiring all insurers to reimburse the CoCM codes.[88]

With health system and philanthropic investments, primary care practices of varying sizes have adopted CoCM, partnering in some cases with specialty behavioral healthcare organizations and in others with technical support organizations to achieve practice transformation and recruit and retain behavioral health clinicians. Examples of several CoCM implementers in Massachusetts are listed below, along with a short description of their CoCM implementations.

Beth Israel Lahey Health (BILH)

BILH uses the Collaborative Care Model to integrate behavioral healthcare for their existing primary care patients across practice settings in their primary care network. The focus of CoCM in the BIHL system is on patients with mild to moderate anxiety, depression, and/or substance use conditions, for whom behavioral healthcare can be managed in a primary care setting. The primary care provider and the Behavioral Health Clinician develop a treatment plan that is specific to the patient's personal goals. They offer evidence-based therapies like Cognitive Behavioral Therapy, Motivational Interviewing, and interventions aimed at problem solving and behavior activation. A consulting psychiatrist is available to advise on medications that may be helpful in treating the patient's mental health condition. Patients meet with the Behavioral Health Clinician every 3-6 weeks for six months to one year, depending on their level of need and response to treatment.

Data gathering for MAMH Improving Outcomes Study confirmed that BIHL has been employing CoCM as the chief method for behavioral health and primary care integration for the past 10 years. BIHL modified its EPIC medical record system and associated billing systems to support CoCM and capture reimbursement for the integrated care provided to its primary care patients. As the BIHL primary care system grows, an established protocol is deployed for orienting and onboarding primary care professionals into CoCM. Publication of research is in progress on the outcomes of CoCM at BIHL.

Family Practice Group of Arlington with The Brookline Center

An effective partnership between Family Practice Group of Arlington, a primary care practice organization, and The Brookline Center, a comprehensive community mental health care organization, was designed to help meet the growing demand for care with support from Accelerate the Future Foundation, a Massachusetts-based philanthropy. Together these organizations are piloting a new partnership approach to implementing the Collaborative Care Model (CoCM) to improve care access and enhance clinical outcomes. Family Practice Group also employs Mirah, a company that provides technical supports and staffing to facilitate CoCM adoption, to manage the development of a patient registry, and make modifications to the medical record and billing systems designed to facilitate provision of, and billing for, CoCM.

Family Practice Group led the implementation of CoCM in January 2024 to alleviate pressure on their 12 clinicians - partnering with the Brookline Center. The Brookline Center recruits and supervises an embedded full time behavioral care manager and provides a part time consulting psychiatrists to the Family Practice Group. Both organizations identify primary care integration as a vital tool to advancing mental health and wellness and improving outcomes for all of Family Practice Group patients' health conditions. The partnership with The Brookline Center has provided them with not only the behavioral health expertise their patients need but also The Brookline Center's unique expertise in behavioral health workforce recruitment and retention.

Integrated care teams work collaboratively on behalf of the primary care patient, creating personalized treatment plans that may include medication, therapy, behavior modification, and social support. Family Practice Group and the Brookline Center are documenting the expanded access and improved clinical outcomes associated with CoCM, and measuring how it leads to higher treatment initiation and completion rates, faster time to clinical improvements, greater patient and provider satisfaction, and reduced healthcare costs. Early signs suggest CoCM also creates a financially sustainable model for both patients and providers. Publication of findings is pending.

Massachusetts General Brigham (MGB)

In 2022 MassHealth launched a value-based payment model requiring primary care providers participating in its accountable care organization (ACO) program to meet standards for team-based, integrated care. Rising to the challenge, in 2023 MGB expanded efforts to implement CoCM with its 400 primary care practitioners, building on a decade of history with use of collaborative care in selected practices and with selected patient groups. MGB engaged Concert Health to an initiative to expand access to integrated care for all patients through implementation of CoCM. Since October 2023, Concert has delivered CoCM services to 6,548 MGB patients, with 1,606 currently receiving care. A total of 190 MGB providers, including primary care physicians, physician assistants, and others, referred patients to the CoCM program in April 2025.

With their robust clinical disciplines, MGB has also been able to extend the use of CoCM from traditional primary care patient populations with mild to moderate anxiety, depression, and/or substance use conditions to other groups with more complex and disabling conditions. MGB has adopted modified forms of CoCM for patients with cancer and serious mental illness. Care teams are multidisciplinary, and include Psychiatry, Oncology, Social Work, and Community-Based Clinicians. MGB has been able to implement CoCM as an alternative to hospitalization for patients with bipolar disorder or schizophrenia, or as aftercare following a hospitalization, where safety is not an issue. In this implementation, hospital-

based behavioral health specialists and supervising clinicians provide support to primary care physicians for straightforward conditions. CoCM teams are configured in different ways with different specialties involved to meet different levels of patient need.

CoCM Service Organizations Provide Implementation Supports

Provider practices in Massachusetts are able to benefit from a growing list of CoCM Service Organizations that offer implementation and ongoing services, including consultation, training, software, billing support and staff (psychiatric consultants and behavioral care managers) to make CoCM accessible to primary care practices and health systems. A compendium of such resources was published last year and will be updated periodically.

Policy Changes to Accelerate Adoption

Policy changes to accelerate CoCM implementation have, as referenced above in this Issue Brief, been underway in Massachusetts for years. To recap earlier statements regarding steps taken in the Commonwealth to provide for reimbursement of the Collaborative Care Model, in 2018 the Massachusetts Division of Insurance (DOI) required that CoCM billing codes be covered by MassHealth managed care organizations (MCOs), Primary Care Clinician plans (PCCs), and commercial health plans in Massachusetts. In July 2021, MassHealth reminded Physicians that it had been covering Medicare psychiatric collaborative case management (CCM) CPT codes 99492, 99493, and 99494, and would henceforth cover CPT code 99484 – Integrated Behavioral Health Care. In January 2022, MassHealth notified all Community Health Centers (CHCs) that a number of codes were available for billing for integrated and collaborative care, including the BHI code (G0511) and the Collaborative Care code (G0512). In August 2022, Chapter 177, the ABC Act was signed requiring all insurers to provide reimbursement for Collaborative Care delivered in Massachusetts.

The MAMH CoCM landscape analysis developed in the Improving Access Study, cited in the previous section, engaged policy stakeholders and practice leaders from three important sectors listed below to contribute their knowledge, experience, and perspectives to inform further CoCM policy, regulatory, reimbursement, and practice transformation efforts. A detailed list of the participating organizations is found in Appendix F. From this work, the following themes emerged:

Payers emphasized use of CoCM as the "gold standard" of integrated care, significance of financial sustainability, the impactful role of a business champion, and the impact of practice transformation that financial and technical support enables to underwrite CoCM practice transformation makes in the feasibility of adoption.

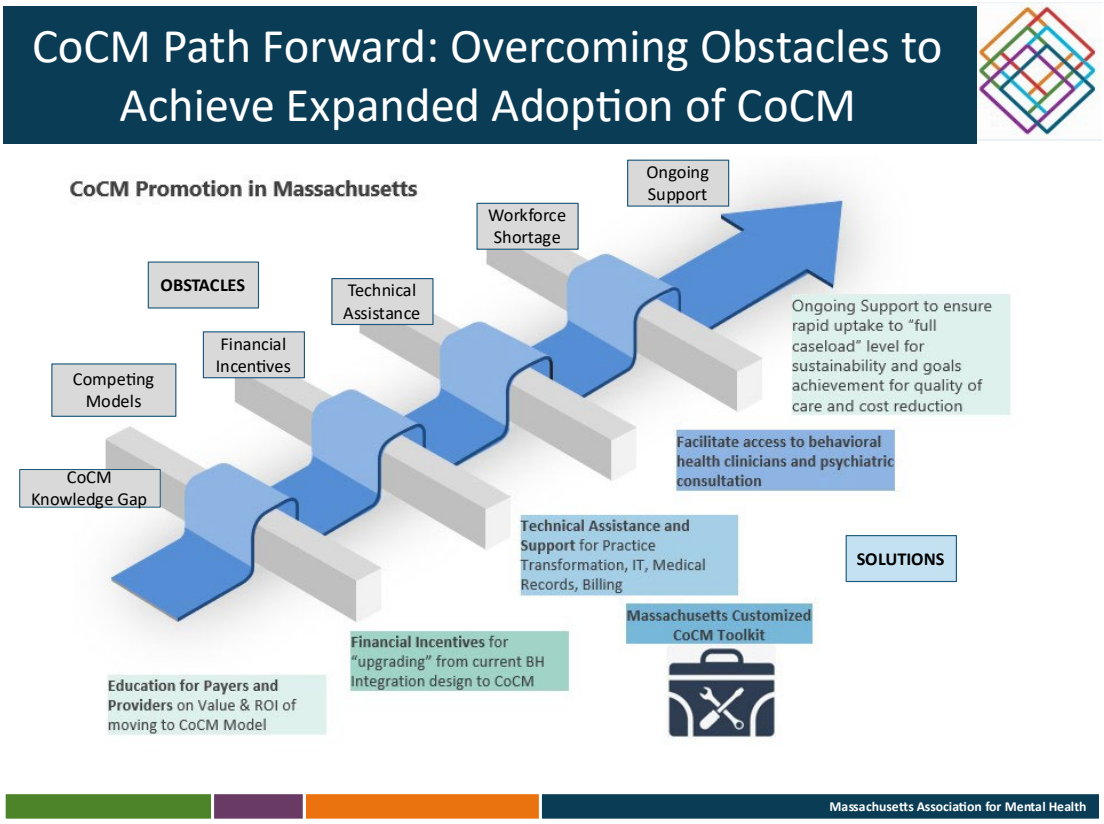
Providers focused on the clinical application of CoCM and its benefits to patients, the need for training and technical assistance, and the challenges of integrating CoCM into existing workflows and electronic health records.

Thought/Policy Leaders discussed the broader implications of CoCM, such as the importance of increasing understanding the clinical problems CoCM addresses, the need for leadership and policy support to succeed in adoption, limited impact of earlier policy and coverage actions, and the potential for legislative or regulatory changes to facilitate its adoption.

Stakeholders agreed on several solvable barriers to CoCM adoption and strategies to address them, including:

- Knowledge gaps
- Start-up investment
- Technical/operational assistance and ongoing support

Table 5. Path Forward in Overcoming Obstacles to CoCM Adoption



CONCLUSIONS

Accessing timely, affordable care for mental health and substance use disorders (MHSUDs) is much more challenging for patients than accessing care for physical health conditions. Yet, inadequate access to these services leads to missed or delayed MHSUD diagnoses, needless patient suffering, preventable suicides and billions of dollars in avoidable medical expenses. As the demand for these services continues to climb, we need solutions that can increase access to effective MHSUD care for the greatest number of people in the shortest period of time.

Our greatest near-term opportunity lies in leveraging our primary care system – approaching MHSUD care the way we approach other medical specialty care. Just as primary care providers (PCPs) systematically screen for and measure cardiac symptoms, provide care for non-acute patients, and refer acute or complex patients to a cardiologist for specialized care, the same can be done for MHSUD patients.

The Collaborative Care Model (CoCM) is an evidence-based service model that enables PCPs to effectively treat commonly occurring MHSUDs such as depression and anxiety in primary care settings. Studies have demonstrated that CoCM leads to improved access to MHSUD care, patient outcomes, increased patient and provider satisfaction, and reductions in suicide risk and total healthcare spending. CoCM can be delivered at low cost and, when the billing codes are paid adequate rates, the monthly cost of delivering CoCM can be recovered through CoCM payment code reimbursement. Over time, the financial benefit grows and accrues to all payers, as savings in total healthcare costs result from reducing physical healthcare expenses for CoCM patients.

In Massachusetts, a consensus has grown among payers, providers, and policy leaders that CoCM offers the best opportunity to improve access to MHSUD care and successfully integrate MHSUD care into primary care. PCPs have expressed an eagerness to learn much more about CoCM and understand how to successfully implement this model. In response, MAMH, NEHI, Health Care For All (HCFA), and others are engaged in activities to support CoCM adoption, including educational webinars and workshops to provide practice leaders with a greater understanding of these considerations, and briefings for policymakers and regulators to address opportunities and challenges associated with implementation.

Accelerating adoption of the Collaborative Care Model (CoCM) in Massachusetts can yield substantial benefits for residents of the Commonwealth, as well as for primary care providers and payers. These include:

- Improving access to effective, affordable care for MHSUDs
- Closing the long gap between onset and identification and treatment of MHSUDs
- Improving clinical outcomes for patients with MHSUDs
- Providing MHSUD care that in a setting preferred by patients
- Preventing unnecessary disability through early intervention
- Reducing suicides
- Reducing Total Healthcare Costs, aiding adherence to Massachusetts Chapter 224 cost growth benchmark goals
- Saving lives and protecting families from critical loss
- Leveraging the primary care system while reducing PCP burnout
  - Increasing the efficiency of scarce MHSUD specialists

Much groundwork has been and continues to be laid across the Commonwealth to facilitate adoption of CoCM. Yet, there is still much to be done. The evidence suggests that actions to accelerate the adoption of CoCM will reap benefits for patient health outcomes and care delivery cost outcomes. These are outlined in the Policy Recommendations set forth below.

POLICY RECOMMENDATIONS TO ACCELERATE ADOPTION OF COCM

1 Medicaid Coverage for CoCM:

a. Provide reimbursement rates for CoCM codes at least equivalent to Medicare rates.
b. Permit FQHCs/RHCs to use the CoCM CPT codes and G2214, in lieu of G0512.
c. Reimburse for CoCM separate from, and in addition to, any care management fees, primary care capitation, or other global payments.

2 Employer and other Commercial Plans:

a. Incentivize providers to adopt CoCM through implementation grants and adequate reimbursement – at least 130%–150% of Medicare FFS reimbursement rates.
b. Encourage patient participation by
    i. treating CoCM as a preventive service, thereby requiring waiver of out-of-pocket CoCM expenses wherever permitted. and
    ii. permitting providers to bill for CPT add-on code 99494 (continued CoCM care) as frequently as clinically indicated.
c. Reimburse for CoCM separate from, and in addition to, any care management fees, primary care capitation, or other global payments.

3 Legislators and Regulators:

a. Allowing in-network CoCM services to count as in-network MHSUD specialist services when assessing Mental Health Parity compliance and network adequacy.
b. Legislation
    i. Enact legislation currently proposed in Massachusetts requiring that reimbursement for CoCM is separate from, and in addition to, any care management fees, primary care capitation, or other global payments.
    ii. Note these Bills filed in the Massachusetts House and Sente in 2024: H.2220 (Rep. LaNatra), *An Act relative to access to psychiatric collaborative care;* S.1390 (Sen. Cyr), *An Act relative to access to psychiatric collaborative care.*
    iii. Permit FQHCs/RHCs to bill using CoCM codes, in lieu of G0512.
    iv. Designate CoCM as a preventive service, thereby requiring waiver of patient out-of-pocket CoCM expenses wherever permitted.
    v. Permit providers to bill for CPT add-on code 99494 (continued CoCM care) as frequently as clinically indicated.

4 Philanthropic and System Funders:

a. Build on successful CoCM adoption initiatives underway or completed.
b. Develop a fund to underwrite costs for practice transformation, technical adjustments to medical records, patient registries, and billing systems, and recruitment and retention of embedded behavioral health clinicians and care managers.

5 Providers: Expand implementation of CoCM, taking advantage of a growing pool of resources to assist with implementation – such as those described in this Directory of CoCM Service Organizations for consultation, training, billing support, patient registries, and ongoing staffing.

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APPENDICES

Appendix A: Comparison of Common Behavioral Health/Primary Care Integration Models

Appendix B: Medicare Behavioral Health Codes Applicable to Collaborative Care

Appendix C: Penn Medicine PIC Program and Kaiser Permanente CoCM Examples

Appendix D: North Carolina Collaborative Care Model Consortium Report

Appendix E: Kaiser Permanente National CoCM Implementation Presentation

Appendix F: MAMH Improving Access Study Participant List

Appendix A – Comparison of Behavioral Health Integration Models

	Primary Care Behavioral Health (PCBH)[i,ii]	Collaborative Care Management (CoCM)[iii]	Consultation-Liaison psychiatry[iv,v,vi]	Co-location of Behavioral Health Clinicians (BHCs) in PCP Office
Population Served	Entire primary care population (any patient, at any time), for a wide variety of BH concerns, or BH influenced behaviors	A clearly defined patient population that meets specific diagnostic criteria	Patients seen in non-psychiatric medical settings who have mental health care needs co-occurring with other conditions or resulting from medical treatments	Patients seen in PCP office, referred to co-located clinician for specific BH concerns
Type of Problems Addressed	Mild to moderate mental health concerns, motivation, medical concerns, health risk behavior, lifestyle behaviors, substance use/smoking cessation, weight management, parent education, guidance and support (in pediatric settings)	Mental health concerns, most commonly anxiety and depression, where improvement has not been noted following primary care intervention	Wide range of problems	Variable; Depends on the expertise of the BHC
Interdisciplinary team-based care	Yes	Yes	Yes	No
Use of a Registry	Sometimes, for certain special populations	Always, for populations targeted for CoCM	No	No
Disciplines of BH Specialists	Typically, psychologists, clinical social workers, and mental health counselors, licensed for independent practice (collectively referred to as Behavioral Health Clinicians, or BHCs)	Psychiatrist (consultant) Care Manager (may not be an independently licensed clinician)	Psychiatrist	Typically, psychologists, clinical social workers, and mental health counselors, licensed for independent practice

	Primary Care Behavioral Health (PCBH)[i,ii]	Collaborative Care Management (CoCM)[iii]	Consultation-Liaison psychiatry[iv,v,vi]	Co-location of Behavioral Health Clinicians (BHCs) in PCP Office
Care Team Roles	Behavioral Health Clinicians (BHCs) are core members of the primary care team and provide direct care to patients/families; BHCs provide consultation to PCPs	Consulting psychiatrist is not part of the primary care team; Care Manager is typically an adjunct member of the care team (may be a core member depending on qualifications/licensure)	Consulting psychiatrist serves as a consultant to primary care providers (outpatient settings), refers patients to specialist care if necessary, and serves as an inpatient consultant if needed.	Co-located clinicians are not members of the primary care team, and function independently, within the physical space of the practice
Treatment/Intervention	Functional/Contextual assessment by BHC; Many single episodes of care focused on immediate concern of patient or PCP; Brief follow-up visits using evidence-based approaches; No defined episode of care	Diagnostic assessment by PCP; Intermittent visits with PCP (or BHC if present) focused on symptom relief using evidence-based approaches; Episodes of care about six months	Psychiatric consultant supports the care of patients seen for other conditions in non-psychiatric care settings, and can manage psychiatric illness in the hospital setting if needed	Diagnostic assessment and intervention using traditional psychotherapeutic approaches; May not be evidence-based; Episodes of care are typically six months or more
Real-time Availability of BHCs	Yes, almost always	Sometimes, depends on staffing	Sometimes, depends on staffing	No. Access is through planned/scheduled visits
Management of Psychiatric Emergencies	Yes, often	Not usually	Yes	No
Use of Evidence-based Measures for Symptom Monitoring	Yes	Yes	Yes	Not typically
BH Specialists Work in Same Facility and EHR as PCPs	BH specialists work in same facility, and utilize a fully-integrated EHR that PCPs also use	Psychiatric Consultant: Does not work in the same facility; does not have EHR access. Care Manager: Works in	Consultation-liaison psychiatrist does not typically work in the same facility and use the same HER as the PCP	Located in the same facility, but utilizing separate EHR

	Primary Care Behavioral Health (PCBH)[i,ii]	Collaborative Care Management (CoCM)[iii]	Consultation-Liaison psychiatry[iv,v,vi]	Co-location of Behavioral Health Clinicians (BHCs) in PCP Office
		same facility and EHR as PCPs		
Delivery of Preventive Interventions	Yes	No	No	No
Revenue Generation	Practice bills for and captures all revenue generated by BHCs	Practice bills for and captures all revenue generated by PCPs and Care Managers	Consultation-liaison psychiatrist bills payers directly and capture all revenue for evaluation and management services	Co-located clinician bills for and captures all revenue generated from services

[i] Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018). The primary care behavioral health (PCBH) model: An overview and operational definition. *Journal of clinical psychology in medical settings*, *25*, 109-126. Url: https://psychologyinterns.org/wp-content/uploads/Reiter2018_Article_ThePrimaryCareBehavioralHealth.pdf

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APPENDIX B – MEDICARE BEHAVIORAL HEALTH CODES APPLICABLE TO COLLABORATIVE CARE

Table X. Medicare billing codes for CoCM, Massachusetts Adoption Status, and current reimbursement rates as of July 2024.

MEDICARE PROVISIONS	MASSACHUSETTS ADOPTION
On January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) activated three new Current Procedural Terminology (CPT) codes enabling payments to physicians and non-physician practitioners in primary care practices to bill for behavioral health services using the "psychiatric care collaborative care model" approach. The codes are: 99492, used to bill the first 70 minutes in the first initial month of collaborative care, in consultation with the psychiatric consultant 99493, used to bill the first 60 minutes in any subsequent months of collaborative care, and 99494. used to bill each additional 30 minutes in any month. Can be used in conjunction with 99492 or 99493. Medicare reimbursement for Massachusetts: 99492 - non-facility fee $158.65-$172.38; facility 94.73-$100.26 99493 - non-facility fee $144.10-$155.36; facility $103.48-$109.54 99494 - Non-facility fee $61.22-$66.19; facility $41.45-$43.88 The practitioner can bill these codes after spending half the allocated time plus 1 minute (for example, at the 36-minute mark for 99492). For all these codes, Medicare pays a single billing practitioner subject to the state law, licensure, and scope of practice that applies to their practice specialty. The billing practitioner seeks patient consent to participate, and either employs or contracts with the other care team members, including the behavioral care manager, psychiatric consultant, and clinical staff.[1] In December 2023, CMS posted a "Frequently Asked Questions" document to clarify how these codes are used.[i] For example, CMS clarified that behavioral health clinicians can bill separately for services provided on-on-one directly to patients as long as that time does not overlap with the CoCM consultation time billed by primary care. FQHCs and Rural Health Centers (RHCs) cannot use these CPT codes.	The Collaborative Care Billing codes were adopted in Massachusetts in 2018 for MassHealth, and pursuant to provision of Chapter 177 of the Acts of 2022 for private insurers, with the exception of self-insured plans. [ii] Reimbursement rates: 99492 – nonfacility fee $114.05; facility $68.25 99493 – nonfacility $107.23; facility $68.25 99494 –nonfacility $43.51; facility $29.85

[1] On January 1, 2018, CMS activated an additional CPT code, 99484, for general behavioral health integration (BHI) services, for BHI models other than CoCM. It requires at least 20 minutes of clinical staff time, in consultation with the psychiatric consultant, can be billed once a month, and cannot be billed for the same patient in the same month as the CoCM codes. MassHealth activated CPT code 99484 starting on July 1, 2021.(See: https://www.mass.gov/doc/physician-bulletin-103-integrated-behavioral-health-service-code-description-and-billing-requirements-0/download). As of May 1, 2024, reimbursement by MassHealth for 99484 stands at $32.34 (non-facility fee) and $21.63 (facility).

MEDICARE PROVISIONS	MASSACHUSETTS ADOPTION
On January 1, 2018, CMS a HCPCS codes for use by FQHCs and RHC[iii]s, which can be used for CoCM: • G0512, for psychiatric CoCM services that require 60 minutes or more of staff time Medicare reimbursement for Massachusetts: **G0512 - $141.83[iv]** FQHCs and RHCs must spend all the allocated time before they can bill.	On January 1, 2022, MassHealth added G0512 to the list of Massachusetts list of HCPCS codes available in Subchapter 6 of the Community Health Center Manual.[v] MassHealth reimbursement: G0512 - $141.83
The 2021 Medicare Physician Fee Schedule added a **Healthcare Common Procedure Coding System (**HCPCS) code for CoCM, for use by FQHCs and Rural Health Centers (RHCs): **G2214 is used to bill for the first 30 minutes in the first month of care or any subsequent month**. CMS indicates this code can be used if a clinician doesn't meet the number of minutes to bill under the CPT codes, for example if the clinician sees the patient and then hospitalizes them or refers them for specialized care. Medicare reimbursement for Massachusetts: **G2214 - non-facility $59.18-$64.06; facility $38.69-$40.95**	Not yet adopted by MassHealth

[i] Centers for Medicare & Medicaid Services (2023). Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services. Available from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf, accessed 7/14/2024

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APPENDIX C – EXAMPLES OF SUCCESSFUL COCM ADOPTION

University of Pennsylvania Health System – PIC Program

Since 2018, the University of Pennsylvania Health System (Penn) has implemented CoCM in more than 50 primary care practices through a program called the Penn Integrated Care (PIC) program. PIC includes all core elements of CoCM, and adds features not traditionally included under CoCM. While CoCM typically is offered to patients with mild to moderate MHSUDs, PIC provides these services for all patients to ensure that these patients needing specialized care are supported. In addition, PIC incorporates a centralized intake, triage, and referral management function - the PIC Resource Center. This resource is designed to allow mental health professionals in practices to use their time more effectively to treat patients.

Primary care patients are referred to PIC through the Resource Center, where they are assessed for CoCM eligibility by intake coordinators (bachelor's level mental health professionals) using standardized mental health screening measures (e.g., Patient Health Questionnaire-9). The intake coordinators are part of the PIC teams, along with the primary care clinician, a master's level mental health clinician, and a psychiatric consultant.

Based on symptom severity, indications of suicidal ideation and/or the presence of comorbid medical conditions, patients may be referred to CoCM services in their primary care clinic or to specialty mental health care in the community. Patients with suicidal ideation are immediately connected with a behavioral health specialist via a warm handoff. The team utilizes an electronic health record registry to monitor PIC patients' treatment progress.

The PIC program has been instrumental in adding to our understanding of the benefits of CoCM in primary care, demonstrating that CoCM can simultaneously improve patients' clinical outcomes and expand the capacity of one FTE psychiatrist by a factor of 10.

Source: Matthew Press, MD and Penn Medicine.

Penn researchers have also recently published two key studies that point to the important role CoCM treatment can play in reducing total healthcare costs and suicide risk among primary care patients.

Impact of CoCM on Total Healthcare Costs

In a study conducted in collaboration with Independence Blue Cross in Philadelphia and published in 2023, total care costs for patients receiving CoCM under PIC were compared to costs from a matched control group. The study found **savings of $29.35 per member per month** (pmpm) in total healthcare costs for PIC patients. While the savings amount was not statistically significant, the study showed that the cost of providing CoCM did not increase overall health care costs.

Importantly, while there were overall savings of $29.35 pmpm, PIC patients in this study incurred **$34.11 pmpm** more in CoCM treatment costs and **$19.91 pmpm** more for other behavioral care costs (non-CoCM related) – indicating that CoCM's impact on total healthcare costs is driven primarily by reductions in non-behavioral medical costs.

Impact of CoCM on Suicide Risk in Primary Care patients

A study published in 2024 by Penn researchers examined changes in suicidal ideation among PIC patients in a community setting. The study found that **52%** of patients determined to be at risk for suicide (based on PHQ-9; item 9) showed reductions in suicidal ideation from their first to their last CoCM visit, with **37%** showing an absence of detectable suicide risk at the last visit. The study also reported significant reductions in **depression** (based on PHQ-9; total score), and **anxiety** (based on Generalized Anxiety Disorder Scale-7 score).

Findings are consistent with evidence from clinical trials suggesting CoCM's potential for increasing access to mental healthcare and improving outcomes among patients at risk for suicide.

Kaiser Permanente – National Implementation of CoCM

In 2011 Kaiser Permanente Colorado implemented a pilot program for Depression Care Management with the following goals:

- Addressing the high prevalence of mental health concerns in Primary Care
- Improving outcomes: depression severity, CVD risk factors (LDL, HbA1C, hypertension)
- Increasing patient satisfaction, functional status, and quality of life
- Decreasing avoidable utilization, ER and hospital admissions
- Increasing access to mental health care
- Meeting/exceeding standards for quality (HEDIS AMM)

The program, which included key components of CoCM, was well received by patients and primary care providers and resulted in improved clinical outcomes for patients and 13% savings in total healthcare costs (detailed further below) for patients enrolled in the program. As a result of the successes seen in the program, it was expanded in 2015 to all Kaiser Permanente locations.

In 2021, Kaiser Permanente made the decision to expand the program further to incorporate all elements of CoCM, based on:

- Increased demand for mental health services

- Further evidence (90+ RCTs)
  - Significantly better treatment outcomes (2x) compared to usual care
  - Reduces total cost of care (6:1 ROI)
  - Effective for youth and adults
- Alleviates outcomes disparities in minority and underserved populations.

The decision was supported by Executive Medical Directors, Health Plan Presidents, Medicare Leads, Primary Care Physician Leaders, National Mental Health Physician and Executive Leadership.

A presentation detailing Kaiser Permanente's transition to implementing CoCM enterprise wide is included as Appendix B.

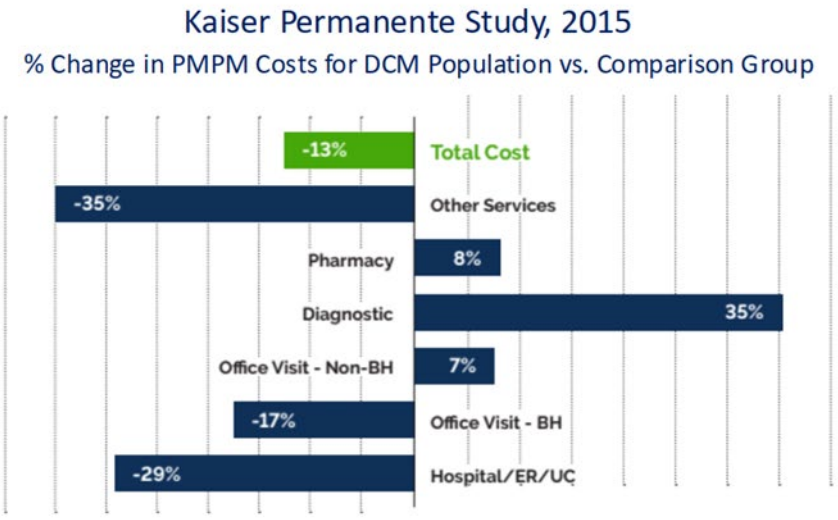
As with Penn, Kaiser Permanente researchers have demonstrated the importance of CoCM in reducing total healthcare costs and suicide risk among primary care patients.

Study of Total Healthcare Costs for Patients Receiving CoCM Compared to Patients Receiving Treatment as Usual (Previously Unpublished; study description detailed here)

In 2015, Kaiser Permanente Colorado conducted a comparison of total healthcare costs (THCs) of 1,525 adult patients with mild to moderate depression receiving CoCM in day-to-day primary care through Kaiser Permanente's Depression Care Management program (DCM).

Treatment for the DCM patients included antidepressant medication and care management in accordance with CoCM, and the THCs for these patients were compared to THCs for similar adult patients receiving "treatment as usual" in primary care during the same time period. Both groups included patients with commercial, Medicare and Medicaid insurance.

The study reported a **13% savings in THC** for the DCM patients versus the comparison group during the 12 months following initiation of care.



Source:
Kaiser Permanente. Previously unpublished information and data from a study undertaken in 2015 regarding total healthcare costs: Collaborative Care Model versus treatment-as-usual. 2024

Kaiser Permanente subsequently expanded the DCM program to all of it regions and, more recently, has expanded the program to include all core elements of CoCM, additional mental health diagnoses (e.g., anxiety), and additional non-medication treatment options).

Effectiveness of Integrating Suicide Care in Primary Care

In this study, suicide care was implemented in combination with CoCM care for depression and substance use. Compared to a large control group of primary care patients receiving usual care, the authors observed a higher rate of safety planning and a 25% reduction in suicide attempts within 90 days of primary care visits among patients receiving this intervention.

APPENDIX D – NORTH CAROLINA COLLABORATIVE CARE MODEL CONSORTIUM SUMMARY

The Collaborative Care Model in North Carolina:
A Roadmap for Statewide Capacity Building to Integrate Physical and Behavioral Health Care

Executive Summary

In January of 2022, North Carolina Medicaid (NC Medicaid) launched a Collaborative Care Model Consortium ("the Consortium"), which included leaders representing the primary care and psychiatric provider communities, payers, and other community organizations. The goal of the Consortium was to expand the availability of integrated mental and primary care services in primary care clinics across the state, using the widely tested and clinically proven *collaborative care model* (CoCM). The Consortium focused on seven strategies that addressed the major barriers to adoption of the model in the primary care setting: financial sustainability and practice operations/change management.

Figure 1. **The CoCM Roadmap**

Steps	Strategies	Actions
Step 1: Aligning Reimbursement Across Payors Goal: Align coverage, requirements and payment across payors to validate that CoCM is an endorsed model worth adopting and reduce administrative burden for providers.	Ensure Coverage of the Same CoCM Codes	• NC Medicaid added coverage of additional CoCM codes to align with Medicare coverage.
		• The Consortium confirmed and promoted widespread commercial adoption of CoCM
	Align Requirements to Bill	• NC Medicaid and other insurers aligned with Medicare requirements on who can serve as the behavioral health care manager.
	Make Reimbursement Sustainable	• NC Medicaid increased reimbursement for CoCM codes from 70% to 120% of Medicare.
	Remove Beneficiary Copays	• NC Medicaid and other insurers removed beneficiary copays for CoCM services.
Step 2: Promoting Streamlined Operations for Adoption and Ensuring Fidelity Goal: Encourage uptake by providing primary care practices with practice resources to make adopting CoCM as easy as possible and ensure that CoCM is implemented with fidelity.	Provide and Fund 1:1 Training for Providers	• NC Medicaid contracted with a Consortium member to provide 1:1 technical assistance and develop education modules focused on different CoCM issues (e.g., best practices in pediatric care, billing codes,
		• Consortium members created learning opportunities for their members (e.g., working sessions at annual meetings, peer-to-peer "solutions" sessions for practice
	Establish Psychiatry Connections	• The Consortium identified 20+ psychiatrists willing to act as psychiatric consultants.
		• The Consortium developed a model contract for psychiatrists and primary care
		• The Consortium developed a customized registry with a set of assessments for adults, children and

Steps	Strategies	Actions
	Customize and Fund a Statewide Registry	• NC Medicaid contracted with a Consortium member to provide Medicaid enrolled providers with free access to the customized state registry ($4K-$7.4K per practice per year) for up to three 3 years.

Over the course of 18 months, the Collaborative met to advance this roadmap, assigning Consortium members leadership roles to drive individual tasks under a work group model. Use of collaborative care services has grown since the launch of the Consortium and the implementation of the capacity building supports developed by the Consortium, with total Medicaid CoCM encounters increasing between 2021 and 2022. With the foundational work now complete, the Consortium is turning its focus on additional capacity building strategies to help practices offset model costs and create a more seamless experience implementing the model in the clinical practice setting.

Context and Introduction

As a result of the leadership of NC Medicaid and the work of a consortium of partners representing payers, providers, and other community groups, the number of North Carolinians with access to integrated behavioral health services in primary care settings is growing. Formed in 2022, the Consortium developed and is now implementing a roadmap for expanding capacity for primary care practices to implement the CoCM, which embeds behavioral health services into the primary care model in a seamless and integrated manner. At its core, the roadmap focused on two primary areas: enhanced financial support via aligned reimbursement across government and private payers, and operational supports and tools to enable practices to launch and manage collaborative care services.

The roadmap, while specific to the North Carolina health care landscape, offers important insights for other states considering their own strategies to promote adoption of CoCM and other primary care based clinical delivery innovations. This report summarizes the key elements of the CoCM model, the strategic roadmap developed by the state to support its adoption, and key success factors from the implementation of the roadmap that others should consider in their own approaches.

Overview of the Collaborative Care Model

The national crisis in behavioral and mental health care continues to worsen, driven by a confluence of factors that include increased prevalence of mental and behavioral health conditions in adults and children, critical access challenges driven by shortages of licensed behavioral and mental health care providers, insurance coverage gaps and low reimbursement rates, and continued societal stigma surrounding many behavioral and mental health disorders. In response, health care providers have been testing innovative ways to bring behavioral and mental health services to children and adults in need.

One approach that providers have tested is the integration of certain behavioral and mental health services into the primary care setting, services that were historically delivered separately. The evidence base indicates that these models deliver better outcomes for patients and families, as well as efficiencies in terms of cost and other factors to the broader health care system.[1]

Several models for integrated behavioral and mental health and primary care services exist. *Figure 2* (page 4) lists selected integration models ranging in intensity of integration of services, providers and the patient experience.

Figure 2. **Continuum of Physical and Behavioral Health Care Integration[2,3]**

	Level of Integration					
	Least					Most
	Coordinated		Co-located		Integrated	
	Screening	**Consultation**	**Care management/ navigation**	**Co-location**	**Health homes**	**System-level integration**
Definition	PCPs identify patients with behavioral health needs and refer them	Consultants work with patients to meet care goals established by PCPs	Behavioral health care managers monitor care plans and treatment programs and coordinate care with patients and PCPs	PCPs and behavioral health providers provide services and collaborate from the same facility	Ongoing care management and coordination, referrals, and support for individuals with complex needs	PCPs and behavioral health providers from the same facility coordinate and collaborate under one management system
Example	Screening, Brief Intervention and Referral to Treatment (SBIRT)	Vermont's Hub and Spoke Model	Collaborative Care Model	Common in FQHCs	Medicaid health homes	Intermountain Healthcare

Note: PCP refers to primary care providers; FQHCs refers to Federally Qualified Health Centers.

CoCM is an example of co-located services, where patients can access behavioral and mental health services in their primary care clinic. CoCM was developed by the University of Washington in the 1990s and is geared toward patients with mild-to-moderate behavioral health conditions. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington defines five "core principles" of CoCM:[4]

1. **Patient-Centered Team Care**, in which providers collaborate to engage patients and provide care;
2. **Population-Based Care**, in which the patient population and outcomes are tracked by practices via a registry;
3. **Measurement-Based Treatment to Target**, in which the patient's treatment plan includes measurable goals and outcomes that treatment is responsive to;
4. **Evidence-Based Care**, in which treatment has a strong foundation of evidence to support it; and
   - **Accountable Care**, in which reimbursement is contingent on the quality of provided care.The team-based structure of CoCM involves three provider types: the billing practitioner, the behavioral health care manager (BHCM) and the psychiatric consultant…The **billing practitioner** is generally a primary care provider (PCP) who uses the expertise of the BHCM and psychiatric consultant to treat a patient's behavioral health problems alongside their physical health concerns.

- The **BHCM** is a professional (e.g., clinical social worker, nurse) who executes care management activities in alignment with the patient's treatment plan. The AIMS Center recommends that this role be performed by a full-time, or nearly full-time, staff member.
- The **psychiatric consultant** is a professional in a support role, generally a psychiatric physician, who acts as a resource to the billing practitioner and the BHCM. The psychiatric consultant's job is to provide virtual consultation, rather than to see the patient.

The bottom line for patients and families is that they can access a coordinated set of services that treat both physical and mental/behavioral health needs in a common setting, with team members able to collaborate on care plans and ongoing management of a person's care in a holistic manner.
CoCM is considered to have one of the strongest evidence bases of any integrated behavioral health model, and more than 100 randomized clinical trials have demonstrated its effectiveness. The evidence shows that CoCM can be cost-effective and impactful for a multitude of settings and population groups.[5]

Early Adoption – and Challenges – for CoCM in North Carolina

The formation of the Consortium came at a time of enormous change in the health care landscape in NC, in large part a result of the State's transition to an integrated, whole-person managed care model for the Medicaid population. Prior to the adoption of managed care, physical and mental health care were bifurcated, making it difficult to integrate care in primary care settings. With the transition to managed care – through which physical and basic mental health services are provided by contracted commercial plans – primary care practices can more easily provide both physical and behavioral health care to Medicaid members with mild-to-moderate behavioral health needs. The development of the consortium also came on the heels of the height of the COVID-19 pandemic and its devastating impacts on physical and mental health in the state and on the provider communities that were on the front lines navigating the public health crisis.

Despite these challenges, the Consortium perceived an opportunity to promote adoption of the CoCM model. There were many examples of the model being adopted in primary care practices within the provider community already, in large part driven by integrated health systems across the state. Duke Health piloted the use of CoCM starting in 2017 and as of 2023 had implemented it in 40 clinics.[6] The University of North Carolina Health (UNC) spent years testing integrated care models and in 2018 launched an effort to implement CoCM that now spans seven primary care practices in urban and rural parts of the state (see "*Case Study: University of North Carolina Health*" for more information).

Case Study: University of North Carolina Health (UNC)

UNC's efforts to promote integrated care are long-standing. Its latest efforts to implement CoCM began in 2018, with a partnership between the Department of Psychiatry and the Department of Family Medicine. That partnership has since grown to encompass seven primary care practices, spanning urban and rural counties. Startup Challenges and Solutions: While UNC has successfully grown its CoCM footprint, the 2018 landscape made it difficult to launch CoCM. Not all commercial payors were reimbursing for CoCM, so UNC limited enrollment to Medicaid and Medicare patients. UNC also experienced challenges covering the costs of employing a full-time BHCM and instead leveraged existing social workers who were supporting the Chronic Care Model deployed in the Department of Family Medicine's practice.

Expanding CoCM: In 2021, UNC decided to broaden the reach of CoCM and invested additional startup funds to expand the number of practices using CoCM. The startup funds were necessary to support practices in the implementation phase, given the ramp-up period needed to recoup investment and reach a financial break-even point. Practice expansion began in earnest in 2022, aligning with the coverage of CoCM by the majority of commercial insurers in North Carolina. Payor alignment, coupled with enhanced Medicaid reimbursement for CoCM, has made the expansion more financially viable. UNC is also seeing positive outcomes associated with the expansion – patients referred to the program due to depression and anxiety are seeing remission in line with the rates indicated in published research on CoCM.

The reimbursement landscape for CoCM had also been changing in a positive direction. The Centers for Medicare & Medicaid Services (CMS) began reimbursing CoCM in Medicare using three Current Procedural Terminology (CPT) codes in 2017, and NC Medicaid followed suit in 2018.[7]

However, despite the efforts of these large systems and the alignment of the government payor reimbursement for CoCM, there was still more limited adoption of the model particularly for the Medicaid population. Between October 2018 and December 2019, only 915 of North Carolina's more than 2 million Medicaid beneficiaries had at least one CoCM claim.[8] Several barriers were still in place. First, commercial insurance coverage of CoCM was not widespread at the time, making it difficult for practices with varied payor mixes to make the financial case for adopting the model and achieving sustainability. Second, the operational startup costs for practices, particularly independent practices with more limited resources, coupled with operational change management requirements, were a significant deterrent for many. The Consortium's efforts would focus on these two issues head on.

Capacity Building for CoCM in NC: The Collaborative Care Consortium

The CoCM Consortium was a natural evolution of successful relationship development and partnership among organizations across the state over recent years. As one example, when the COVID-19 pandemic hit in 2020, a cross-section of community partners came together to develop a "Navigating COVID-19 webinar series" to help providers across the state navigate the pandemic, covering topics such as how to apply for funding for personal protective equipment, improve the implementation of telehealth and more.[9] The series became a starting point for a collective effort to promote CoCM and the formation of the Consortium followed in January, 2022.
The Consortium is led by NC Medicaid and sponsored by NC Medicaid's Chief Medical Officer. It meets regularly and includes a Steering Committee, whose members (see *Appendix A*) led four subcommittees:

- **The Clinical Advisory Workgroup**, which aims to build connection between stakeholders and support best practices for implementation;
- **The Logistics Workgroup**, which aims to develop the CoCM registry and psychiatric consultation contracts;
- **The Alignment Workgroup**, which aims to coordinate and align payors in reimbursing for CoCM; and

- **The Communications and Training Workgroup**, which aims to build supports for practices to implement CoCM and develop trainings and enduring resource materials.

The Consortium worked through three phases to prepare, build and execute a plan to promote adoption of CoCM. The Steering Committee met initially on a monthly basis to report on the efforts of each subcommittee, which provided an opportunity to address challenges as they arose. On multiple occasions, the Consortium developed new and creative tools to address key challenges, such as a matchmaking service to help primary care practices connect with psychiatrists, and a data dashboard to monitor utilization and identify practices that might benefit from additional resources (more on these solutions in the next section, "The Roadmap").
Regular meetings fostered accountability among Consortium members, many of whom remarked in interviews that they wanted to be sure they had completed their "homework" before meetings. As the work progressed and meetings moved from monthly to quarterly, Consortium members continued to engage with each other and identify solutions to promote CoCM.

The Roadmap

There are several operational changes practices must undertake to implement the CoCM model:

- Hiring and training a BHCM;
- Training practice clinical staff – primary care physicians, physician assistants, nurses – on the model;
- Updating clinical and electronic health record (EHR) workflows;
- Implementing a registry to track member engagement, ideally one that integrates with the EHR; and
- Training practice management and billing staff on COCM codes and billing best practices.

Consortium members estimate that the startup cost for a practice to adopt CoCM is roughly $30,000 over the first three months of implementation when accounting for the costs of hiring a BHCM, staff training and contractual payments to the psychiatric consultant (*Figure 3*). These startup costs make the long-term financial sustainability of CoCM a critical factor in whether practices are willing to adopt the model.

Figure 3. The Cost of Implementing CoCM10

Activities in the First 3 Months of Implementing CoCM	Cost
Salary and Fringe Benefits for Behavioral Health Care Manager	$19,500
Psychiatric Consultation Time	$3,500
Primary Care Clinician Training and Implementation Time	$5,000
Staff Training	$2,500
Total	$30,500

In recognition of the resources required to adopt CoCM, the Consortium focused its initial efforts (The Roadmap) on two key steps:

- Step 1: Aligning reimbursement across payors; and
- Step 2: Promoting streamlined operations for practice adoption to ensure fidelity.

Within these two key steps, the Consortium employed a variety of strategies to make adopting CoCM as easy as possible while ensuring practices implemented it with fidelity.

Step 1: Aligning Reimbursement Across Payors

From the beginning, the Consortium recognized that aligning reimbursement across payors, to the extent possible, would send a signal that CoCM was a model worth adopting. Alignment across payors would also streamline the requirements providers and practices must comply with in order to bill for CoCM services provided.

To promote alignment across payors, the Consortium made sure that all payors were covering the same set of CoCM codes, requirements to bill were aligned, reimbursement was sustainable across payors and beneficiary copays were removed.

Strategy 1a: Ensure Coverage of the Same CoCM Codes

The Consortium first compiled information on what codes were covered across different in-state payors and Medicare, to understand gaps in coverage that might discourage providers from implementing CoCM. Without broad alignment in coverage for CoCM, practices working with a variety of payors did not have a strong incentive to adopt the model.

An initial gap was coverage of CoCM codes by Blue Cross and Blue Shield (BCBS) of North Carolina, one of the largest commercial payors in the state. Beginning July 1, 2022, BCBS of North Carolina began covering CoCM codes for its members, and by midway through 2022 the Consortium confirmed that virtually all major commercial and individual marketplace payors covered CoCM (see *Appendix B* for the full list of payors the Consortium confirmed covered CoCM). Commercial coverage, coupled with existing Medicare and Medicaid coverage, meant that any insured individual in North Carolina would have CoCM services covered if offered by their primary care provider.

In addition to general coverage of CoCM across payors, NC Medicaid also adopted two new codes – G2214 and G0512 – over the course of 2022 to match the set of CoCM codes covered by Medicare. Prior to the addition of these codes, NC Medicaid covered procedure codes 99492, 99493 and 99494 (see *Figure 4*).[11]

Figure 4. North Carolina Medicaid Covered Procedure Codes and Rates[12]

Procedure Code	Procedure Code Description	Facility Rate	Non-Facility Rate
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month	$109.94	$176.23
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities	$120.82	$171.30
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month	$49.24	$73.14
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.	$32.70	$50.93
G0512	Rural health clinic (RHC) or federally qualified health center (FQHC) only, psychiatric collaborative care model, (psychiatric COCM) 60 minutes or more of clinical staff time for psychiatric CoCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month	$124.53	$124.53

Strategy 1b: Align Requirements to Bill

Beyond coverage of CoCM codes, the Consortium identified discord in billing requirements across payors in its early review of payor alignment. A key area of difference was who could serve as the BHCM. In its initial coverage of CoCM codes, NC Medicaid did not allow nurses or unlicensed, but trained, behavioral health staff to fulfill the BHCM role. Excluding these providers from fulfilling the BHCM role diverged from Medicare requirements, meaning that practices using a nurse to fill the BHCM role could bill Medicare for CoCM services but not Medicaid. Beginning in March 2022, however, NC Medicaid modified its definition of who could serve as a BHCM to align with Medicare, making it easier for practices to comply with billing requirements across payors.

Strategy 1c: Make Reimbursement Sustainable

The Consortium also recognized that in order to make CoCM viable for practices to adopt, payors would need to reimburse CoCM codes at a rate that would be financially sustainable. In December 2022, NC Medicaid increased its reimbursement of CoCM codes from 70% to 120% of Medicare, increasing the incentive for providers to adopt CoCM in their practices.[13] Practices have already credited the reimbursement increase with making the adoption of CoCM more feasible in the state (see "*Case Study: One Health and C3/MindHealthy*").

Case Study: One Health and C3/MindHealthy

In 2022, One Health – a group of primary care practices in and around Charlotte – and MindHealthy PC – a company focused on helping primary care providers adopt CoCM – partnered to implement CoCM across One Health's primary care practices. As of June 2023, the partnership had embedded CoCM in five One Health practices, with the goal of having all 29 practices using CoCM by the end of 2023. One Health shared that the decision by NC Medicaid to increase CoCM reimbursement and broaden payor alignment has made the adoption of the model more financially sustainable.

The Partnership: One Health had attempted, without luck, to implement CoCM in the years leading up to its partnership with MindHealthy. Through the partnership, MindHealthy provides One Health with virtual behavioral health care managers, psychiatric consultants and case management technology for registry management and time-based code tracking. MindHealthy is also now

integrated into One Health's EHR and handles the CoCM registry.

Measuring Success: While practice implementation is still underway, One Health and MindHealthy plan to track numerous metrics, such as enrollment, screening (e.g., GAD-7, PHQ-9), retention, readmissions and average reimbursement. They are also surveying patients and providers to understand satisfaction with the model. As of June 2023, approximately 60% of One Health patients referred to CoCM were enrolled in the model.

Strategy 1d: Remove Beneficiary Copays

Another key strategy employed by the Consortium was to encourage payors to remove copays for CoCM services. Under the CoCM billing structure, providers can bill for services provided even when a patient is not directly engaged. If a payor requires a copay for all CoCM services, however, patients may be charged a copay without ever interfacing with their providers, which can lead to confusion and potential payment noncompliance. NC Medicaid and other commercial insurers opted to remove copays for CoCM services, streamlining payment requirements for beneficiaries.

Step 2: Promoting Streamlined Operations for Practice Adoption to Ensure Fidelity

In addition to promoting payor alignment, the Consortium recognized that practices would need additional supports to make it easier to adopt the new model with fidelity. These practical supports included practice-specific technical assistance, opportunities to establish a connection with a psychiatric consultant and initial funding to enable participation in a customized statewide registry.

Strategy 2a: Provide and Fund 1:1 Training for Providers

To ensure practices interested in CoCM had easy access to information, NC Medicaid contracted with the North Carolina Area Health Education Centers (NC AHEC) to provide technical assistance and coaching. As of July 2023, NC AHEC had engaged in 850 one-on-one encounters with practices on a variety of topics (see "*Most Common Topics Covered in CoCM Technical Assistance Discussions*"). NC AHEC has also developed 10 on-demand, online education modules focused on different CoCM issues

(e.g., best practices in pediatric care, billing codes, brief therapeutic interventions) that 680 participants had completed for continuing education credit. Beginning in 2024, NC AHEC is also planning to develop peer-to-peer sessions for individuals serving as BHCMs.

In addition to the formal practice supports funded by NC Medicaid, Consortium members have created learning opportunities for their members. For example, the North Carolina Pediatric Society featured CoCM topics at in-person meetings, including sessions for practice managers and staff, and many Consortium members have hosted sessions on CoCM at their annual meetings.

Most Common Topics Covered in CoCM Technical Assistances (TA) Discussions

- Providing an overview of the CoCM model
- Determining the appropriate patients on their panel
- Analyzing the economic feasibility of the program and how long it will take to achieve break-even status
- Providing guidance on the appropriate type of person for the BHCM role and the duties expected and sharing best practices for recruitment
- Recruiting a psychiatric consultant
- Implementing a data registry, including the Medicaid-funded opportunity
- Training on billing/coding
- Using telehealth versus on-site care
- Discussing clinical and administrative workflow redesign and calibration
- Helping PCPs and BHCMs understand and align with expected roles, duties and referrals

Strategy 2b: Establish Psychiatry Connections

A key component of the CoCM model is establishing a relationship with a psychiatric consultant. While some providers in North Carolina have existing relationships with psychiatrists who could fulfill this role, the North Carolina Psychiatric Association (NCPA) distributed a survey to its members trained in CoCM by the American Psychiatric Association to see which psychiatrists would be willing to serve as a psychiatric consultant. Through the survey, NCPA identified more than 20 psychiatrists across the state willing to serve as consultants to a primary care practice and created a "matching" survey for practices to complete if they were interested in connecting with a potential psychiatric consultant. The survey asked for information on the practice size, type, patient population and more (see *Appendix C*). NCPA and the North Carolina Academy of Family Physicians (NCAFP) also developed a streamlined model contract for primary care practices and psychiatric consultants to use to formalize their relationship with minimal administrative burden for practices. Taken together, the goal was to make identifying and establishing a relationship with a psychiatric consultant as easy as possible.
While few matches have been created thus far, Consortium members indicated that practices adopting CoCM

have been able to tap into other existing resources, such as relationships with individuals who participate in the North Carolina-Psychiatry Access Line (NC-PAL), to source psychiatric consultants.

Strategy 2c: Customize and Fund a Statewide Registry

Adopting CoCM also requires practice to develop a registry to track patient outcomes and engagement. Creating a registry that can integrate with existing practice EHRs requires significant resources, however, and has historically been a barrier to adopting CoCM. To address this issue, Consortium members decided to explore implementing a centralized, statewide registry to ease this burden on practices. After considering different options, the Consortium settled on using a customized version of the AIMS registry. The customized registry includes a set of assessment tools covering three age groups and four conditions (see *Figure 5*).

Figure 5. Assessment Tools in Statewide Registry by Age Group

	Condition			
Age Group	Depression	Anxiety	ADHD	PTSD
Children	✓	✓	✓	X
Adolescents	✓	✓	✓	X
Adults	✓	✓	X	✓

The following tools are embedded in the customized registry, by age group:

- **Children:** Short Mood and Feelings Questionnaire (SMFQ) for Parent and Child, Screen for Child Anxiety Related Emotional Disorders (SCARED) for Parent and Child, and the National Institute for Children's Health Quality (NICHQ) Vanderbilt Assessment Scale for Parent and Teacher.
- **Adolescents:** Patient Health Questionnaire (PHQ-9) modified for adolescents, SCARED for Parent and Child, and the NICHQ Vanderbilt Assessment Scale for Parent and Teacher.
- **Adults:** PHQ-9, General Anxiety Disorder-7 (GAD-7) and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5).

NC Medicaid contracted with Community Care of North Carolina (CCNC), a long-standing medical home system with a history of supporting primary care practices, to provide Medicaid-enrolled providers with free access to the customized state registry (equivalent to approximately $4,000-$7,400 per practice per year) for up to three years. Practices that first engaged with NC AHEC and were interested in participating in the statewide registry were referred to CCNC to set up registry access (see "*Case Study: Dayspring Family Medicine*" for an example of one practice that worked with both CCNC and NC AHEC to adopt CoCM).

As of June 2023, nine practices are using the statewide registry. All practices using the registry have agreed to allow NC Medicaid to access information in the registry, and in the future the Consortium plans to aggregate findings on outcomes and engagement to track CoCM rollout.

Case Study: Dayspring Family Medicine

In November 2022, Dayspring Family Medicine in Eden, North Carolina, began working with NC AHEC to adopt CoCM in an effort to expand access to mental health services to its residents. Mental health care in the area has historically been located far from the populations Dayspring serves. In March 2023, the practice officially launched the model when a former nurse who had been with Dayspring for over two decades, became the office's first BHCM. Since implementing CoCM, Dayspring's caseload has grown to include over 60 patients, with demand continuing to increase for CoCM services.

CoCM Implementation: Dayspring employs a virtual psychiatric consultant with whom the BHCM meets once a week. Their meetings leverage the AIMS caseload tracker, which CCNC supported Dayspring in setting up, to identify patients who require treatment adjustments.

Startup Challenges and Solutions: The primary issues that Dayspring has faced in its CoCM implementation are capacity and startup billing issues with insurance companies. With only one BHCM on staff, the demand for CoCM is beginning to outpace the BHCM's capacity (a recommended 65-70 patients per BHCM). Additionally, entities paying Dayspring experienced system issues with tracking CoCM codes, resulting in slowed reimbursement. NC AHEC's CoCM coaches continue to work with Dayspring's practice manager to rectify CoCM billing problems and other challenges as they appear.

Success Factors

Besides the tactical steps taken by the Consortium to align reimbursement across payors and create tools and resources for practices to use to streamline CoCM adoption, several other factors contributed both to the success of the Consortium and to the uptake in adoption of CoCM utilizing the resources organized by the Consortium. Those included:

1. North Carolina's CoCM built on consensus among major stakeholders.
    - ✓ NC's collaborative brought major stakeholders to the table to ensure all parties were on board with decisions.
    - ✓ The process was iterative, and all decisions were documented.
    - ✓ The Consortium leveraged long-standing, existing relationships that had tackled prior behavioral health care integration initiatives.
2. Statewide leaders representing different stakeholder groups championed the idea of promoting CoCM, and NC Medicaid leadership helped drive the work forward.
    - ✓ Several statewide leaders, who became consortium members, brought the idea of promoting CoCM to NC Medicaid. They also served as CoCM champions within their broader networks, ensuring prioritization of CoCM and expanding the reach of the Consortium's efforts.
    - ✓ Stakeholders noted that having a central champion in a significant leadership position, in this case NC Medicaid's Chief Medical Officer, was essential. Having a leader who prioritized and regularly promoted the initiative was a major reason for its success and helped justify resources spent on the initiative.
3. The timing was right…

- ✓ The state implemented NC Medicaid Managed Care Standard Plans in July 2021, which removed a barrier between physical and mental health by enrolling individuals in integrated, whole-person managed care plans that covered both physical and basic behavioral health services.
- ✓ The structure of managed care assigned mild-to-moderate behavioral health patients to the Standard Plans, which empowered primary care practices to leverage innovative approaches to implement whole-person care.
- ✓ The COVID-19 pandemic, although it magnified behavioral health concerns in the state, also brought these conditions to the forefront.

4. Medicaid aligned its collaborative care policies with those of Medicare and provided funding.
   - ✓ NC Medicaid ensured its policies aligned with those of Medicare, so providers would not have to worry about noncompliance.
   - ✓ The state agreed to reimburse 120% of Medicare rates for the model and contracted with stakeholders to cover the cost of other practice supports.
5. North Carolina provided practical supports that aimed to streamline implementation for providers as much as possible.
   - ✓ Consortium members developed learning opportunities for members.
   - ✓ NCPA created a consulting psychiatrist match program.
   - ✓ NCAFP and NCPA developed a baseline model contract that all consulting psychiatrists and PCPs implementing the model could use.
   - ✓ The Consortium developed a customized registry and provided Medicaid-enrolled providers free access for up to three years.
6. CoCM implementation allowed flexibility across policies where possible, allowing implementation to be responsive to capacity issues across the state.
   - ✓ North Carolina allowed multiple professionals to fill the role of BHCM.
   - ✓ Medicaid did not require the consulting psychiatrist to be enrolled in Medicaid as a condition for reimbursement.
7. The Consortium use focused efforts to promote the model.
   - ✓ Consortium members convened opportunities for their members interested in the model to connect.
   - ✓ NC AHEC provided 1:1 training and technical assistance for providers to implement CoCM.

Monitoring Evolving Efforts

The Consortium has stayed nimble as new challenges emerge, with one ongoing challenge around how to monitor the Consortium's efforts – how widely CoCM has been deployed throughout the state, the impact of the practice supports and outcomes from the model – given that the data are spread among stakeholders. CoCM is only one model among a spectrum to promote integrated behavioral and physical health care, and some providers across the state have employed other models (e.g., co-location), making it difficult to track the full scope of integrated care efforts across the state. Further, Consortium members indicated that not all providers are billing CoCM codes, which could lead to an undercount of services provided in analyses of Medicaid utilization.

To address these challenges and track progress, NC Medicaid developed an integrated, interactive care dashboard to track CoCM Medicaid encounters across the state, including by geography, race, ethnicity, age,

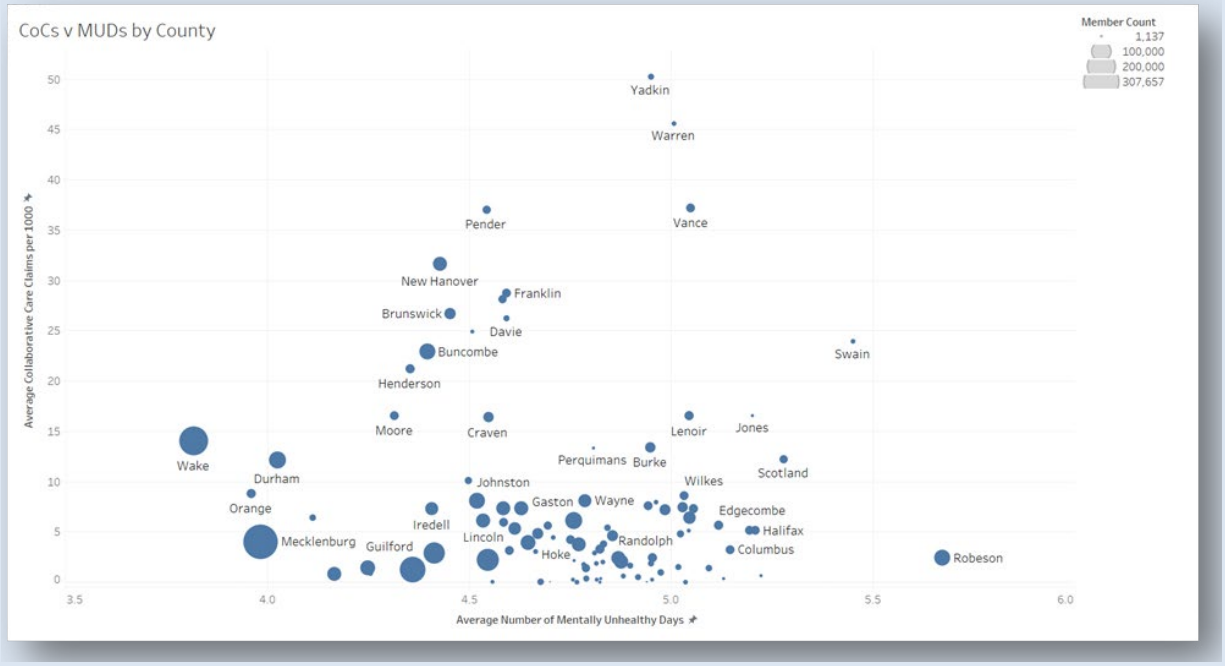
Medicaid program (fee for service versus managed care) and provider type (e.g., independent providers, hospital-affiliated providers, FQHC). The Consortium is leveraging the dashboard to identify parts of North Carolina that would benefit from targeted efforts to promote CoCM (see *"The Data Dashboard in Action"* for examples of dashboard figures).

The Data Dashboard in Action

In *Figure 6,* NC Medicaid examined Medicaid claims in conjunction with non-Medicaid data sources, in this case the average number of mentally unwell days from the Behavioral Risk Factor Surveillance System.

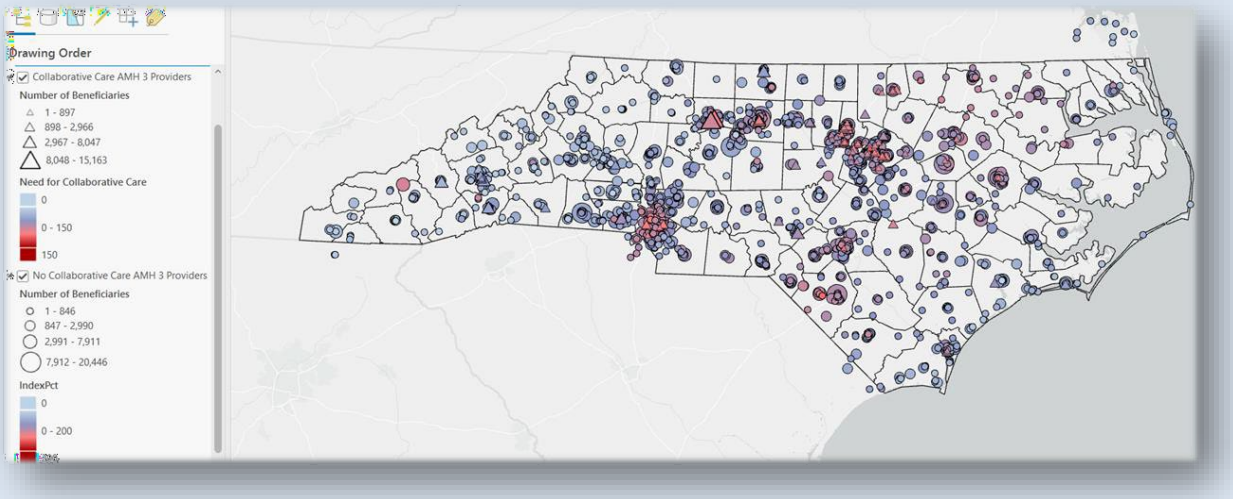
Counties in the lower righthand corner, like Robeson County, could be candidates for targeted efforts to promote CoCM given they are experiencing a higher average number mentally unwell days and fewer CoCM claims. *Figure 7*, a visual focused on a smaller geographic level, compares practice-level CoCM penetration to Medicaid member need. Practices indicated by red circles (i.e., practices not providing CoCM but with a higher patient need for behavioral health services) could be candidates for targeted efforts to promote CoCM. Both figures highlight the creative way NC is using claims data to deploy increasingly targeted practice supports.

Figure 6. **Average CoCM Claims by Average Number of Mentally Unhealthy Days**[14]



Note: Counties in the lower right are those that are in higher need of behavioral health care but experiencing lower access to CoCM. CoCM claims span Jan. 1, 2019, to May, 24, 2023.

Figure 7. **Practice-Level Penetration of CoCM Relative to Medicaid Member Need**



Note: "Need for Collaborative Care" is identified by: the percentage of a practice's beneficiaries that have given birth in the prior 12 months, have been diagnosed with anxiety or depression in the prior 12 months and/or are a member of a historically marginalized population.

Future Opportunities

While the Consortium has many successes to celebrate – and efforts outlined in The Roadmap have encouraged practices that had not previously adopted CoCM to do so – uptake of the model has not been as robust as initially hoped. As the Consortium and its members learn from the experiences of providers implementing the model and utilizing different resources, it is actively planning for the next phase of its work and focus. Several major opportunities have been identified, and planning will continue over the coming months and years.

Focus 1: Supporting practices in offsetting startup costs for the CoCM

Adopting CoCM has an estimated startup cost of roughly $30,000 per practice over the first few months (see *Figure 3*, page 8), largely driven by costs associated with the ramp-up of the BHCM and other staffing-related costs due to new clinical workflows.

North Carolina explored opportunities to cover these costs, including Medicaid capacity-building programs. Using its managed care authority, NC Medicaid could establish a capacity-building program that would allow the state to flow funding to providers and other entities that invest in CoCM implementation via their managed care contracts. Medicaid would set investment priorities for the program, such as hiring/contracting with a BHCM or contracting with a psychiatric consultant, and practices that fulfill the investment priorities would be eligible for funding to offset their investments. Given the numerous requirements to implement capacity-building programs, however, North Carolina ultimately decided not to pursue this approach.

In addition to capacity-building programs, North Carolina explored other opportunities to offset the startup costs of CoCM, including North Carolina's Medicaid expansion sign-on bonus, private funders/philanthropy, organized payor-funded capacity-building programs and federal grants. At the time of this publication, North Carolina had recently passed a budget with substantial investments in behavioral health, including $5 million earmarked for capacity building for primary care practices across the state to adopt CoCM.

Focus 2: Developing a pipeline for necessary workforce (e.g., BHCM)
One of the biggest barriers to implementation is hiring a BHCM, due to shortages of available providers. The Consortium is considering models that might increase both the capacity of the current BHCM workforce (i.e., utilization of virtual models across practices) and pipeline development programs, which could include new education/training programs, third-party vendors and other strategies.

Focus 3: Peer-to-peer opportunities
In interviews with primary care practice administerial and clinical staff, opportunities to connect to peers and share best practices and tools was noted as a major opportunity (see *"Interview with a BHCM: Key Themes and Opportunities"* (page 17) for more on this and other future opportunities from a current BHCM in North Carolina). The state is exploring ways to connect practice managers, BHCMs and other stakeholders to enable them to troubleshoot challenges and teach/learn from each other. These connections would also create forums to engage practices that have not adopted the model and encourage them to adopt.

Interview with a BHCM: Key Themes and Opportunities

1. Be prepared for the demand for CoCM: Dayspring did not anticipate how high the demand would be for CoCM once launched. Patients have been receptive to the model, given the quick and regular access to behavioral health services that it provides.
2. Start with a part-time BHCM: The BHCM started in their role as a part-time BHCM. The slow ramp-up allowed Dayspring to organize and be responsive to practice-specific issues not covered in AIMS Center trainings, such as adjusting to the North Carolina billing environment.
3. Walk through challenge scenarios, and process questions with peers: Dayspring's Insurance Department could have used better support before the model was adopted to anticipate the various scenarios it would encounter in billing for CoCM. Dayspring also found issues in preparing its EHR to have the necessary options to provide and track mental health services. The BHCM believes that certain hurdles could have been avoided had they known the types of questions to ask in the beginning and had other experienced entities to learn from.
4. Leave room for a ramp-up period: The BHCM noted that it is important for practices to have everything (e.g., the EHR system, the number of people to be added to the system) figured out prior to launch. Practices should give themselves time to troubleshoot issues, rather than attempting to implement at 100% capacity.

Focus 4: Engaging larger health systems
The Consortium has predominately engaged with independent practices so far, with engagement of larger health systems occurring on a more limited basis. This includes some of the early adopters of CoCM in North Carolina, such as UNC, Duke, and Novant Health. While the Consortium's technical assistance and financial supports are not limited to independent practices, the lack of engagement by larger systems highlights a need for varied approaches to encourage and understand CoCM efforts based on practice size, scope and ownership. The Consortium is currently exploring ways to foster connections with larger health systems and understand their existing efforts around CoCM in order to bring integrated services to more North Carolinians.

Appendix A: Collaborative Care Consortium Steering Committee Participants

CoCM Consortium Member Affiliations	Member Job Titles
AmeriHealth Caritas	• Chief Medical Officer
Blue Cross and Blue Shield of North Carolina	• Medical Director • Medical Director of Behavioral Health Value Transformation
Carolina Complete Health	• Chief Medical Officer
Community Care of North Carolina (CCNC)	• President & CEO
Healthy Blue	• Chief Medical Officer
North Carolina's Division of Health Benefits (DHB)	• Chief Medical Officer for North Carolina Medicaid • Associate Medical Director for Behavioral Health • Chief Quality Officer for North Carolina Medicaid
North Carolina Area Health Education Centers (NC AHEC)	• Director
North Carolina Academy of Family Physicians (NC AFP)	• Executive Vice President & CEO
North Carolina's Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS)	• Deputy Chief Psychiatrist
North Carolina Division of State Operated Healthcare Facilities (DSOF)	• Chief Medical Officer for Behavioral Health and IDD
North Carolina Pediatric Society (NC Peds)	• Executive Director
North Carolina Psychiatric Association (NCPA)	• Executive Director
UnitedHealthcare Community Plan	• Chief Medical Officer
WellCare	• Chief Medical Officer

Appendix B: Payor Alignment in North Carolina

Payor Name	Covers CoCM Codes	Aligned with Medicaid/ Medicare on BHCM Definition
Medicaid Prepaid Health Plan		
AmeriHealth Caritas North Carolina	Yes	Yes
Blue Cross and Blue Shield of North Carolina	Yes	Yes
UnitedHealthcare of North Carolina	Yes	Yes
WellCare of North Carolina	Yes	Yes
Carolina Complete Health	Yes	Yes
Commercial		
Blue Cross and Blue Shield	Yes	Yes
UnitedHealthcare	Yes	Yes
Aetna	Yes	Yes
Cigna	Yes	Yes
Marketplace		
Ambetter of NC	Yes	Yes
WellCare of NC	Yes	Yes
AmeriHealth Caritas	Yes	Yes
UnitedHealthcare	Yes	Yes
Blue Cross and Blue Shield	Yes	Yes

Appendix C: Psychiatric Consultant Matching Survey

See below for snippets of the Psychiatric Consultant Matching Survey. The full survey can be accessed here: https://ncpsych.memberclicks.net/cocm-matching?servId=10829#!/

Are you looking for a psychiatric consultant trained in Collaborative Care?

The American Psychiatric Association trained ~4,000 psychiatrists and 400 primary care physicians around the country in the **Collaborative Care Model (CoCM)** and many of them are here in North Carolina!

These trained psychiatrists are ready to start working with you to implement the model in your practices!
Please complete the requested information below to begin the match making process.

Please tell us about you:

Respondent's Name

Respondent's Position/Title:

Phone Number:

Email:

Next, tell us about your practice:

Practice Name:

Where is your practice located?
Address, City, State, Zip

Which county is your practice in?
(None)

Practice Phone Number:

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13. Ibid.
14. North Carolina Medicaid CoCM Data Dashboard, June 2023.

Appendix E – Kaiser Permanente National CoCM Implementation Presentation

The Collaborative Care Journey at Kaiser Permanente (KP)

Patricia deSa, MS

Director, National Mental Health, Wellness & Addiction Care

Implementation Lead, National Collaborative Care Management

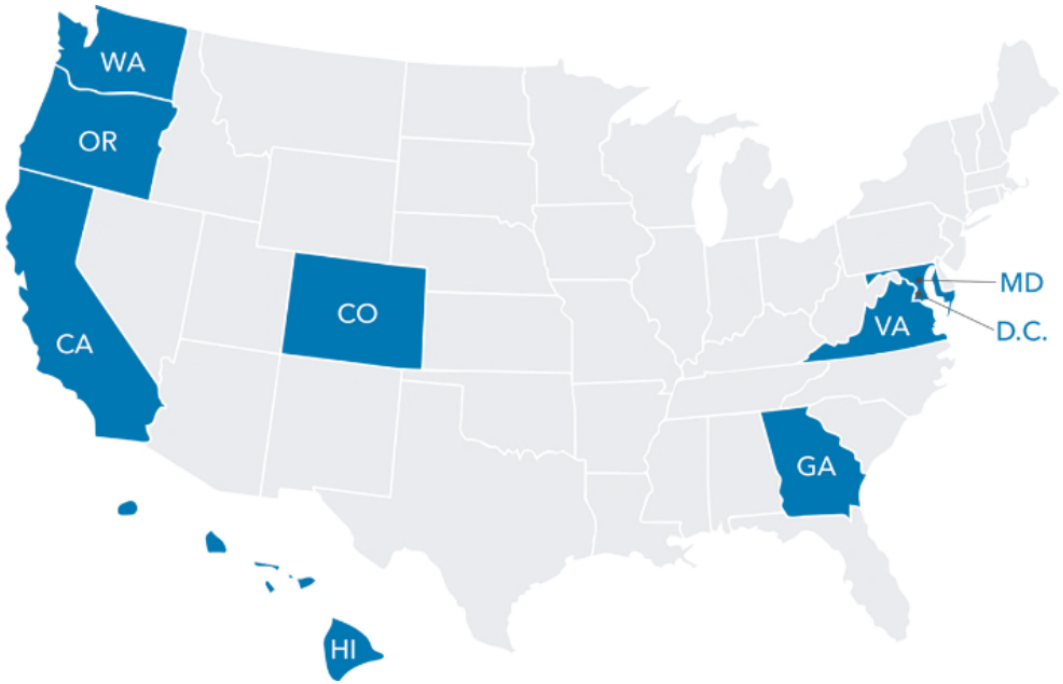
national | **mental health, wellness, and addiction care**

KAISER PERMANENTE®

Disclaimer

No conflicts of interest to disclose.

Kaiser Permanente at a Glance
(about.kaiserpermanente.org)



Founded
1945

Headquarters
Oakland, Calif.

Members
12.5M

Hospitals
40

Medical offices[1]
618

Physicians[2]
24,605

Nurses[3]
73,618

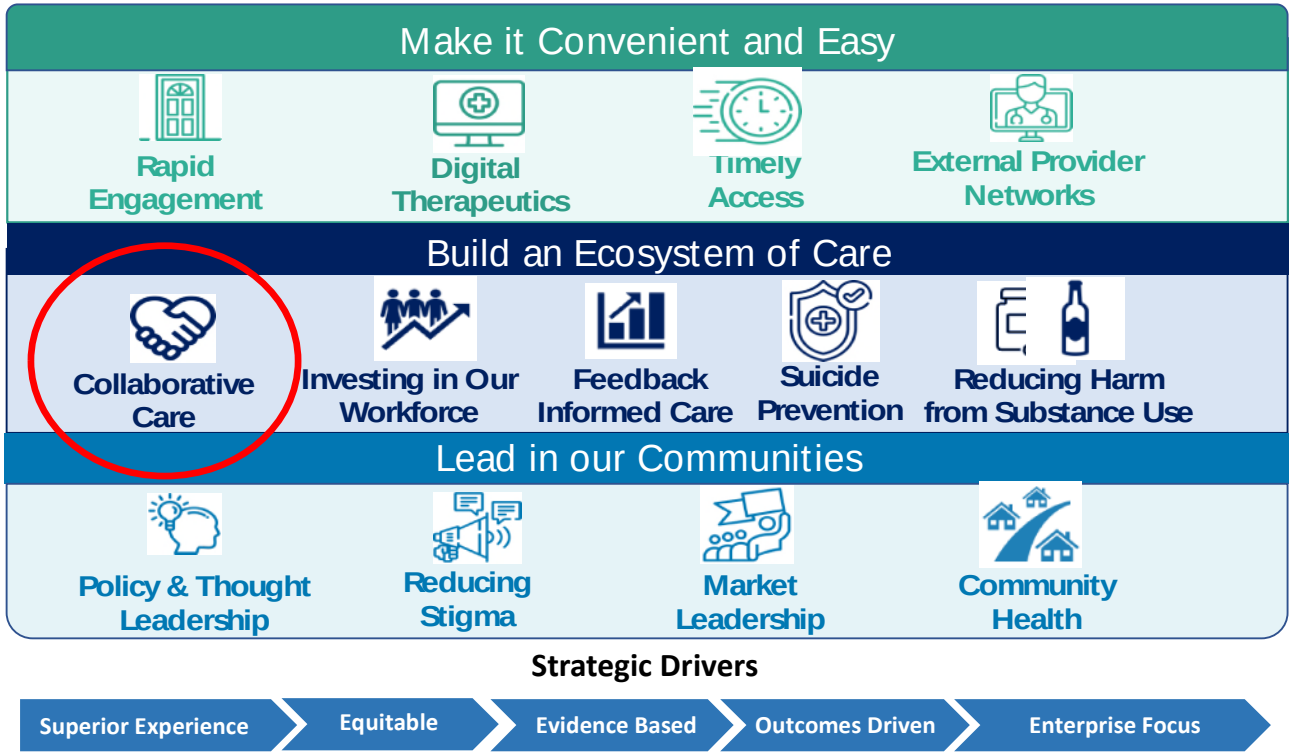
Employees[+]
235,785

<u>Mission:</u> Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

1,2,3,* Data as of December 2023

KP's National Mental Health, Wellness, and Addiction Care Program

Our vision: Anyone, at any time, in any place, can achieve mental well-being and recovery from addiction.



Early Research: Two KP sites participated in the original IMPACT trial

Original Contribution FREE

December 11, 2002

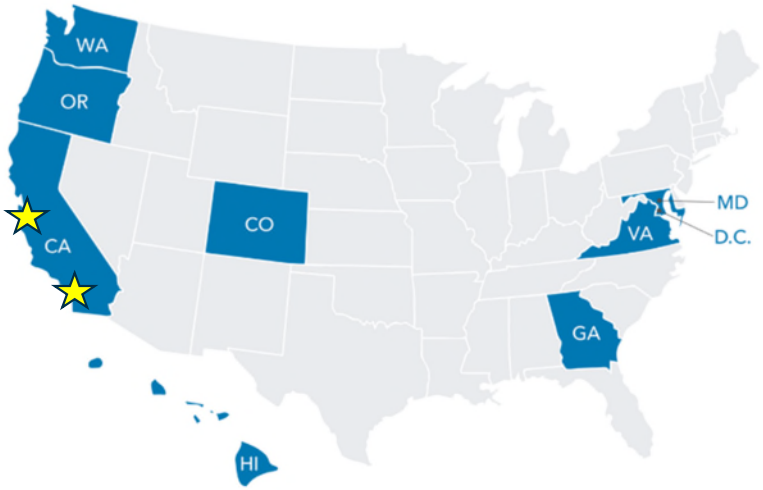
Collaborative Care Management of Late-Life Depression in the Primary Care Setting

A Randomized Controlled Trial

Jürgen Unützer, MD, MPH; Wayne Katon, MD; Christopher M. Callahan, MD; et al

Author Affiliations

JAMA. 2002;288(22):2836-2845. doi:10.1001/jama.288.22.2836

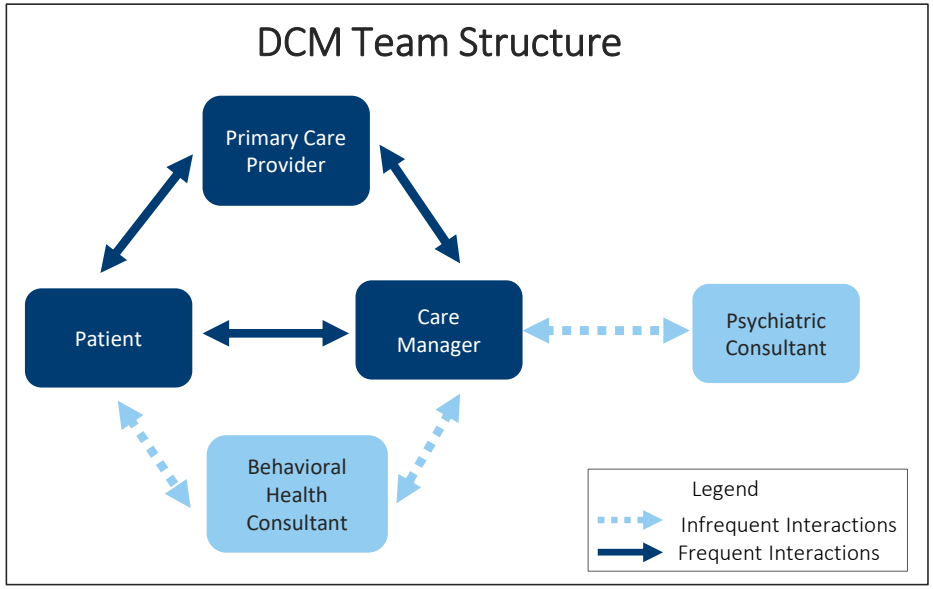


The 2011 KP-Colorado pilot of Depression Care Management

Why?

- **Address high prevalence** of mental health concerns in Primary Care
- **Improve Outcomes:** depression severity, CVD risk factors (LDL, HbA1C, hypertension)
- **Increase** patient satisfaction, functional status, and quality of life
- **Decrease** avoidable utilization, ER & hospital admissions
- **Increase** access to mental health care
- **Meet and exceed standards** for quality (HEDIS AMM)
- ***It's the right thing to do!***

KP Colorado's Depression Care Management Model



- **Target population:** 18+, new depression diagnoses, new medication start
- **BH Care Managers:** Registered Nurses
- **Modality:** Telephone-based (no cost)
- **Intervention:** Medication management, brief interventions
- Minimum 4 clinical encounters with an average program length of 3-6 months

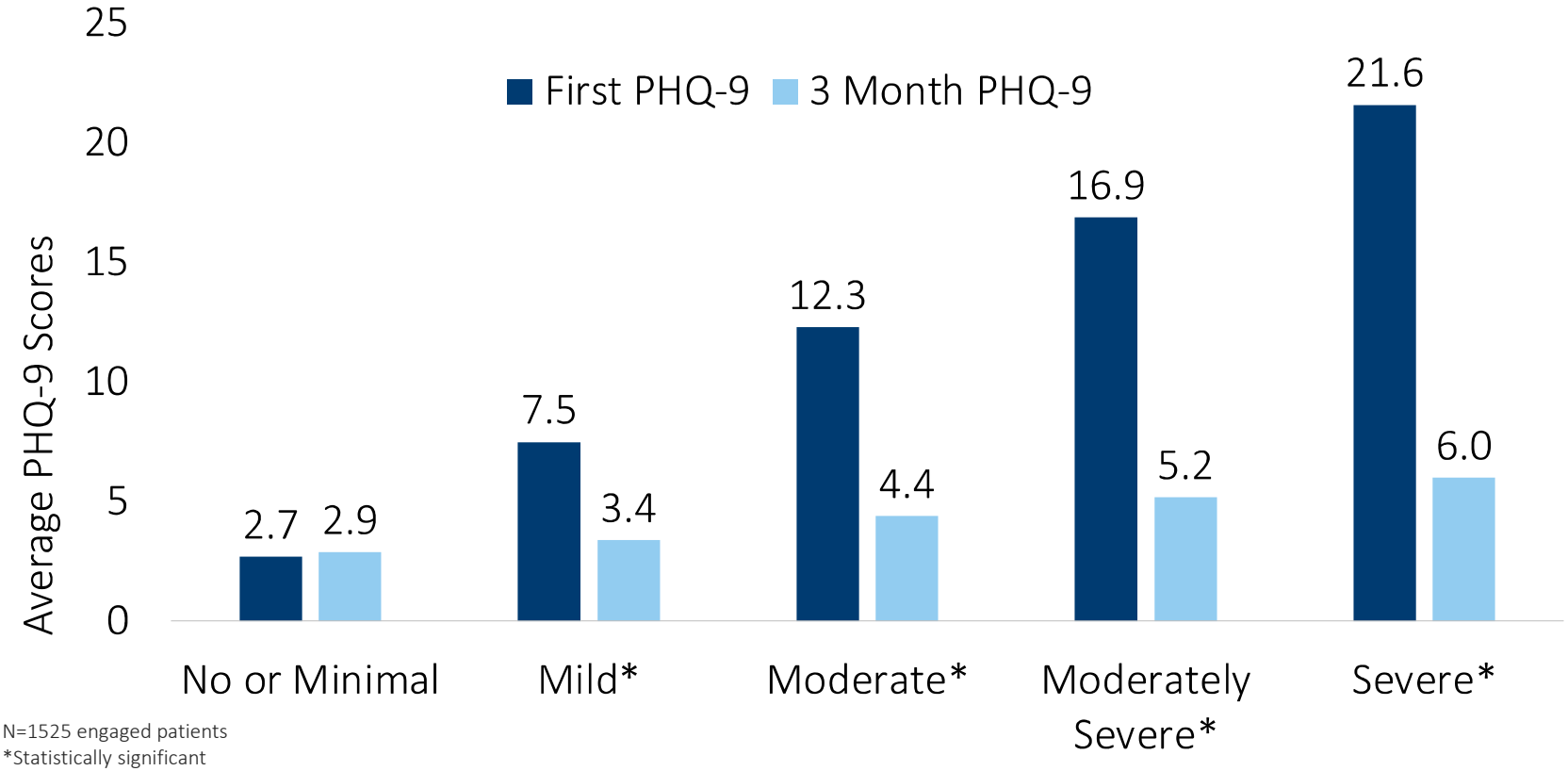
Encounter 1
1-3 days after med start

Encounter 2
2 weeks after med start
PHQ-9

Encounter 3
4 weeks after med start or increase
PHQ-9

Encounter 4
4 weeks after Encounter 3
PHQ9

KP Colorado 2015 DCM Evaluation: PHQ9 Scores for Engaged Participants



N=1525 engaged patients
*Statistically significant

Positive Member and Clinician Response

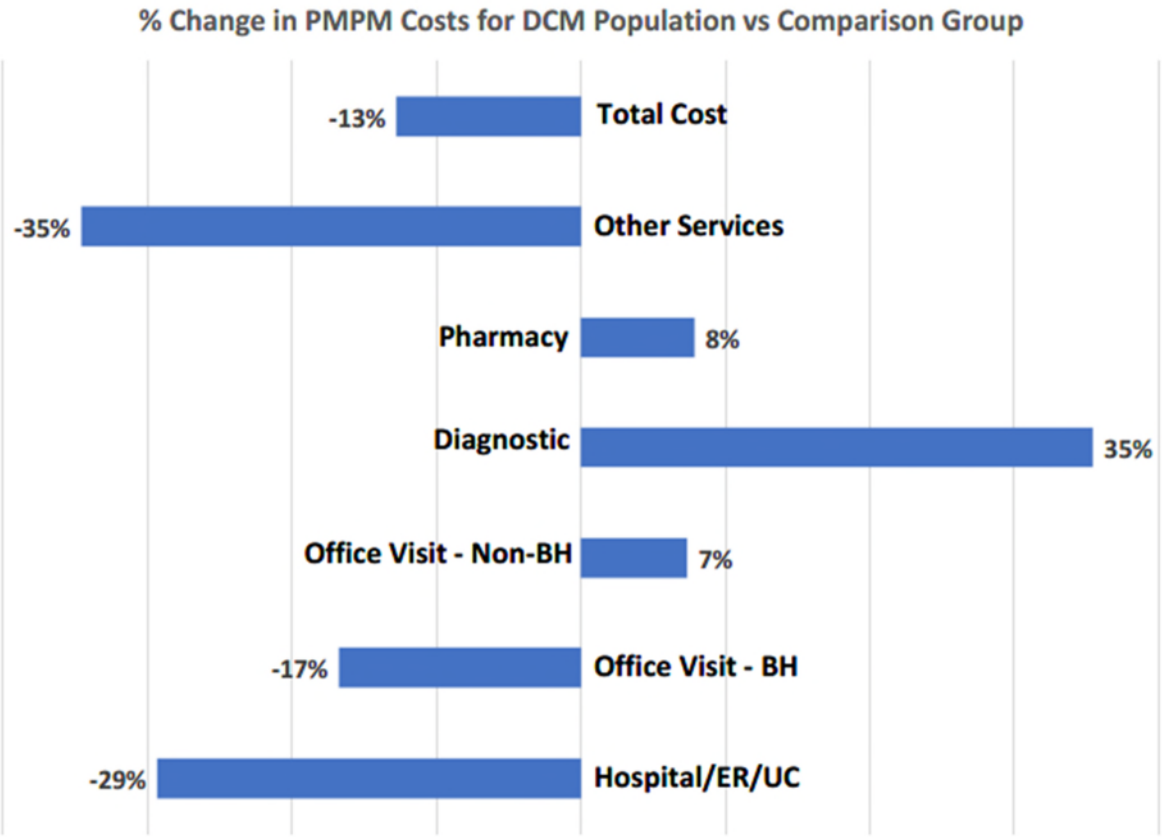
"My primary doctor made me feel good and cared for, but **my nurse really made me feel important.** Like she actually was invested in my progress and how my medication was working."

– KP member

"This program has proved really helpful to provide that support to patients and **get them feeling better relatively quickly in a way that's pretty cost-effective**. We're able to work with a large number of people with just a few care managers and that frees up the providers to be working with folks on their other medical issues."

– BH Care Manager

KP Colorado DCM 2015 Cost Analysis

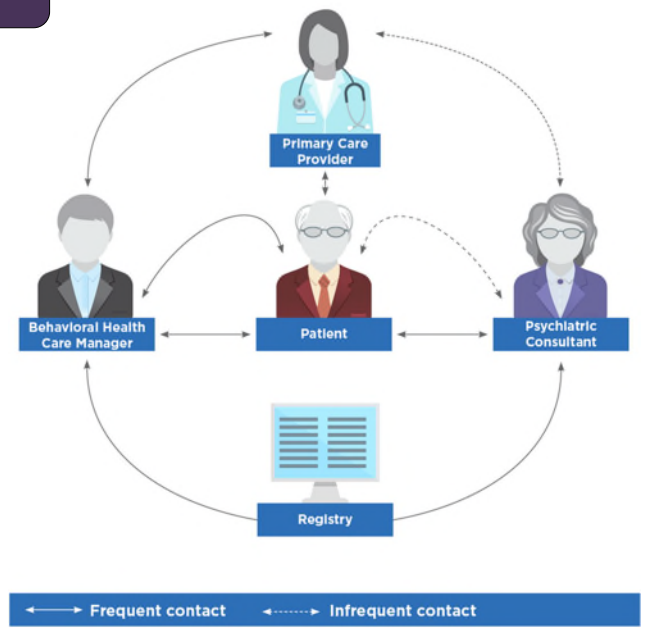


Continuing the Journey: A *National* Depression Care Management Program

2015 - 2021

Depression Care Management

- **(18+) New Diagnosis**
- **Depression**
- **Moderate to Moderately Severe**
- **Medication Only**
- **RN**



Why?

- Further evidence of effectiveness (~80 RCTs)
- Evidence of reduced costs
- New HEDIS metrics for depression (DSF, DMS, DRR)
- Aligned with KP Medicare and Quality goals
- Improved access
- ***It's the right thing to do!***

Leadership Support

- Medicare Accountable Leads
- Permanente Physician Quality Leaders
- Health Plan Vice Presidents of Quality
- National Mental Health & Wellness Executive and Physician Leadership

How we expanded Depression Care Management Across the Enterprise

1. Dedicated national **implementation, analytic, and clinical leads.**
2. **Implementation playbook** with a step-by-step guide for implementing the KP Colorado model
3. **Learning collaborative** that shared resources, best practices and innovations
4. **Member and clinician interviews** to understand what was working and what could be improved.
5. **National metrics dashboard** that included process and outcomes: initiation, engagement, response, remission
6. **Performance improvement** project in two regions focused on improving engagement rates

What we learned

Leadership support was key at the national and local levels

For members that completed the program, **outcomes were consistent with literature**

Primary Care physician endorsement was key to patient initiation and engagement

Patients found the program to be **seamless and supportive**

Virtual program made care more accessible and satisfying

Positive Member and Clinician Response

"The response is very rapid and very assuring. I feel like there's **someone supervising and helping me through it.**"

– KP member

"There are patients that have said that they **wouldn't seek mental health support if we hadn't reached out.** That's something that I found to be very rewarding and is working well."

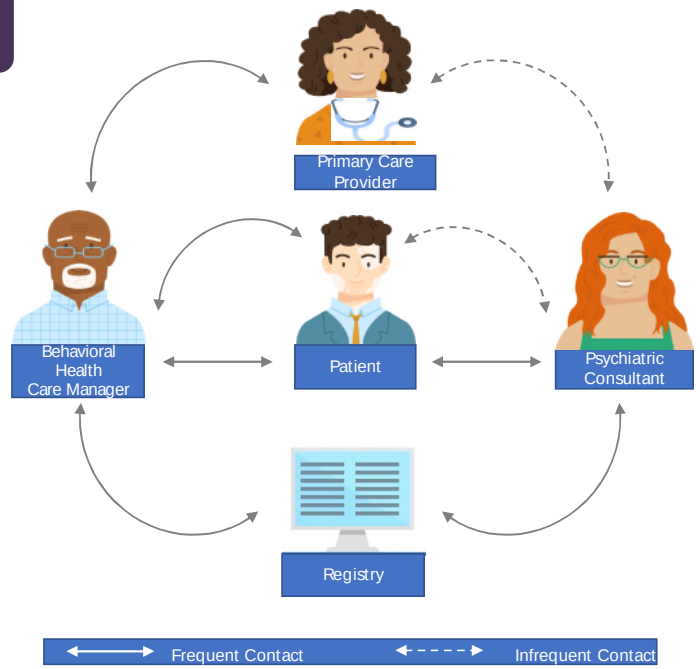
– BH Care Manager

Continuing the Journey: Expansion from DCM to Collaborative Care

2021 – present

Collaborative Care Model

- (18+) New and Existing Diagnoses
- Depression and Anxiety
- Moderate to Moderately Severe
- Medication and Counseling
- RN, LCSW, PhD, PharmD, coaches, etc.



Why?

- Increased demand for mental health services
- Further evidence (90+ RCTs)
  - Significantly better treatment outcomes (2x) compared to usual care.
  - Reduces total cost of care (6:1 ROI).
- Effective for youth and adults
- Alleviates outcomes disparities in minority and underserved populations.
- ***It's the right thing to do!***

Leadership Support

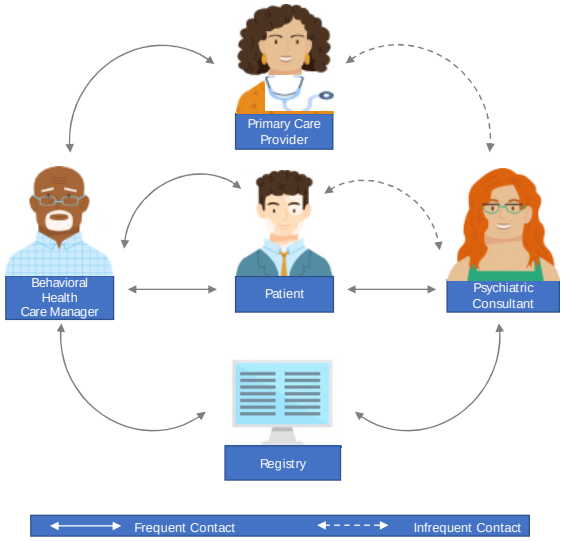
- Executive Medical Directors
- Health Plan Presidents
- Medicare Leads
- Primary Care Physician Leaders
- National Mental Health Physician and Executive Leadership

Continuing the Journey: Collaborative Care Management

2021 – present

STRONG EMPHASIS ON HIGH FIDELITY AND THE 5 ESSENTIAL COMPONENTS

- 01. PATIENT-CENTERED TEAM CARE
- 02. POPULATION-BASED CARE
- 03. MEASUREMENT-BASED TREAT TO TARGET
- 04. EVIDENCE-BASED CARE
- 05. ACCOUNTABLE CARE



Enhancements (not in all regions)

- Adolescents (13+) and OB/GYN patients included in target population

- Clinical pharmacist
- Care manager support staff
- Virtual care clinician

- Social health screening
- Weighted priority

- Social health referrals
- Integration of health and wellness resources including digital tools

Positive Member and Clinician Response

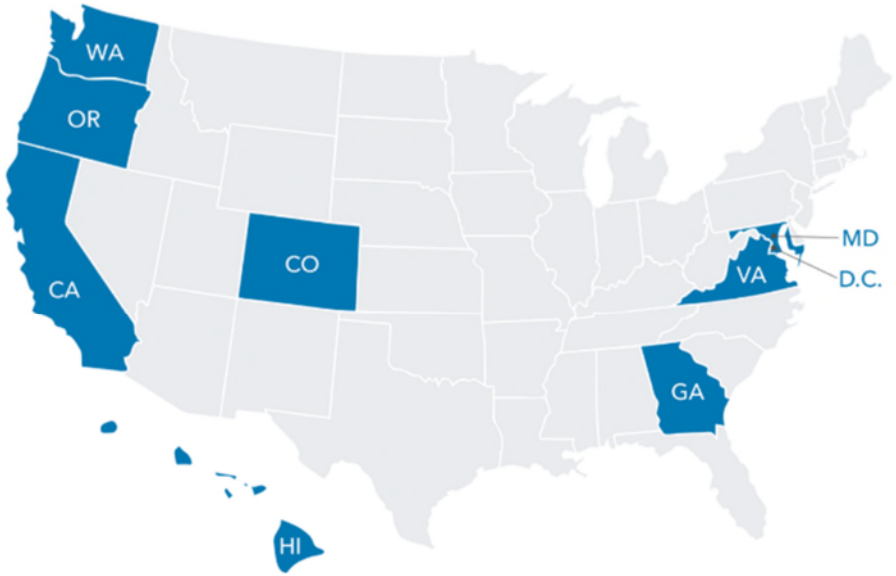
"Teamwork was very important. I would say **everybody worked together**…I felt that [the team] had a sense of urgency to help the patient."

– KP member

"We've had other members who have just not found usual care comfortable: Perhaps having to drive to a different site to meet with the therapist when they felt they needed support acutely. **We're able to identify patients in the middle of a doctor's appointment**, with their primary care provider. They're able to initiate our brief behavioral interventions or counseling within the program."

– Psychiatric Consultant

How's it going



Launched and expanded in 7 regions; 8th region pending

01. Successes

- Partnership with UW AIMS: Toolkit, coaching, training
- Community of Practice: to share successes and resources
- Cost model to support business cases for expansion
- Member and clinician testimonials/satisfaction
- Primary care champions

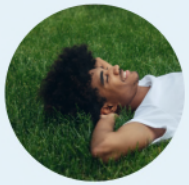
02. Challenges

- Additional resources/FTE
- Building up caseloads
- Confusion with other integrated models
- Technical issues with registries

03. On the Horizon

- Internal training capability
- National measurement dashboard with disaggregation
- Expansion to other departments including OB/GYN

Positive Member and Clinician Response



"I tell everybody about this awesome program that Kaiser has. Everything that this program has come to offer has been amazing. I think just **having that support and knowing that somebody is there that understands** what you're going through is a huge, huge thing for me."

– KP Member

"It's the **one stop shop for all your mental health needs**. It'll make sure not only that you know the medication adjustments and steps are sorted out with the patient in mind, but also making sure that they're plugged into whatever else they need. So, it's really like autopilot. And if [members] qualify it, I'd say by all means recommend it, because it seems like a **win-win for everybody**."

– Virtual Care Physician

Questions?

APPENDIX F – MAMH IMPROVING OUTCOMES STUDY

STAKEHOLDER PARTICIPANTS

Stakeholders included the following organizations that were represented in key informant interviews, policy briefings, consensus panels, and research convenings:

Thought & Policy Leaders

- Accelerate The Future Foundation
- AIMS Center, U. Washington
- MA Primary Care Alliance for Patients (MAPCAP)
- Blue Cross Blue Shield MA Foundation
- Bowman Family Foundation
- Center for Health Information and Analysis
- Concert Health
- Dell Medical School
- Massachusetts Health Policy Commission
- Metrowest Health Foundation
- Meadows Mental Health Policy Institute
- National Council for Mental Well-Being
- Network for Excellence in Health Innovation (NEHI)
- The Goodness Web

Payer Organizations

- Blue Cross Blue Shield of MA (BCBSMA)
- Carelon Behavioral Health (formerly Beacon Health Options)
- Centers for Medicare & Medicaid Services (CMS)
- Community Care Cooperative (C3)
- Massachusetts Association of Health Plans (MAHP)
- Mass General Brigham (MGB) Health Plan
- MassHealth
- Optum

Health Care Providers

- Atkinson Family Practice
- Bay State Health System
- Boston Children's Hospital
- Boston Medical Center
- Brookline Center for Mental Health
- Cambridge Health Alliance
- Family Practice Group of Arlington, MA
- Massachusetts Behavioral Health Partnership (MBHP), a Carelon Behavioral Health Company
- Massachusetts Child Psychiatry Access Program (MCPAP)
- Massachusetts League of Community Health Centers